

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville 8.</i>				c. LENGTH OF STAY IN 1b <i>4 yrs</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7628 Carla Rd</i>				d. STREET ADDRESS <i>7628 Carla Rd</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>SYDNEY BERNARD ALBERT</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>6</i> Year <i>1957</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 1, 1914</i>			
9. AGE (In years last birthday) <i>43 yrs.</i>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Jewelry</i>		11. BIRTHPLACE (State or foreign country) <i>Balto.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>									
13. FATHER'S NAME <i>Isidore Albert</i>				14. MOTHER'S MAIDEN NAME <i>Lola Ruch</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>yes</i>		16. SOCIAL SECURITY NO. <i>216-65-0817</i>		17. INFORMANT <i>Henry Goldsmith - 3464 Labarinto Rd.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>								INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>none</i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>None 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State) <i>None</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>S. D. Caples</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <i>12-6-57</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<i>Burial</i>		<i>12-8-57</i>		<i>Herring Run</i>		<i>Balto Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i>				ADDRESS <i>2100 Eutaw Place</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 10 1957</i>			
				24b. REGISTRAR'S SIGNATURE <i>Doncheyewell</i>					

RECEIVED

DEC 10 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12708

12732

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>				c. LENGTH OF STAY IN 1b <u>6</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 304 Gumspring Rd.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2. Raspeburg 6</u>				
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Steven</u> Middle <u>Carol</u> Last <u>Amos</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1957</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-57</u>	9. AGE (In years last birthday) yrs. <u>5</u> Months <u>5</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 1 YEAR Months <u>5</u> Days <u></u>			IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>								
13. FATHER'S NAME <u>Alfred Amos</u>				14. MOTHER'S MAIDEN NAME <u>Ella May Dorsey</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Father</u> Address <u>Box 304 GUMSPRING RD.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>499X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause lost. (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>John C. Hyle</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. COUNTY, MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph B. Lock, Jr.</u>				ADDRESS <u>1304 N. Central Ave</u>		24a. REC'D BY REGISTRAR DATE <u>12/17/57</u>		
				24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Thompson</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 13 1957

RECEIVED



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12733 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>52</b> <b>Catonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>637 Coleraine Rd.</b>		d. STREET ADDRESS <b>637 Coleraine Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>ANDREWS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1919</b>
9. AGE (in years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Body Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>McKeesport, Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>- Andre</b>		14. MOTHER'S MAIDEN NAME <b>- Fulmer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs. Catherine L. Andrews, 637 Coleraine Rd</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		DATE SIGNED <b>12/26/57</b>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 30. 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>4300 Old Frederick Rd. Balto. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>THOMAS J. KENNY, INC. 1000 HOLLINS ST. BALTO. MD.</b>		24a. REC'D BY REGISTRAR <b>DEC 27 '57</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

TIME OF DEATH

BUREAU V. R.

DEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12710

12734

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Baltimore City</b> Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>51 Days</b>				d. STREET ADDRESS <b>512 Cording Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BERNARD</b> Middle <b>---</b> Last <b>APPEL</b>				4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 10, 1897</b>	
9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Roofing Business</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Bernard Appel</b>				14. MOTHER'S MAIDEN NAME <b>Ida Berndt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>216-10-1351</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO <b>UNKNOWN CAUSE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>			
1. <b>Gangrene, right foot. 2. Multiple sclerosis. Operation - Hemorrhoidectomy, 10 years ago.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>VA</b> Month <b>10</b> Day <b>28</b> Year <b>19 57</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>VA</b>				20g. (County) <b>VA</b>		20h. (State) <b>VA</b>	
21. I certify that I attended the deceased from <b>October 28, 1957</b> to <b>December 18, 1957</b> and that death occurred at <b>8:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Maryland</b> DATE SIGNED <b>12/18/57</b>							
ACTUAL SIGNATURE <b>Joseph M. Miller</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>JOSEPH M. MILLER, M.D., Chief, Surgical Service</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 21, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Govans Presbyterian Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>				ADDRESS <b>3000 E. Baltimore St., Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. Fisher</b>	

# CERTIFICATE OF DEATH

BUREAU V. S.

DEC 23 1957

RECEIVED

12735

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3401.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON RIDGE NURSING HOME</u>		d. STREET ADDRESS <u>943 WEBB CT</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>ARMAN</u> Middle <u>ARMAN</u> Last		4. DATE OF DEATH <u>DEC.</u> Month <u>16th</u> Day <u>MON.</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JACOB</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES CHMIELEWSKI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>DOROTHY EIN WILIT 49-ILP MANVOIR</u>		Address <u>RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>14y pulmonary &amp; Arterio sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/10/1957</u> , to <u>12/16/1957</u> , that I last saw the deceased alive on <u>12/13/1957</u> , and that death occurred at <u>2:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 Edmondson Ave</u> DATE SIGNED <u>12/16/57</u>			
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u> <u>4605 EDMONDSON AVE.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>DEC 19 57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

BUREAU V. B.

DEC 19 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12736

## CERTIFICATE OF DEATH

Reg. Di 12712

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7224 Eastern Ave.</b>		d. STREET ADDRESS <b>7224 Eastern Blvd</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>E</b> Last <b>ATKINSON</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 4, 1872</b>
9. AGE (In years last birthday) yrs. <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>track foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Cecil Co., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Elisha A. Atkinson</b>	
14. MOTHER'S MAIDEN NAME <b>Isabel Jay</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>705-69-7438</b>		17. INFORMANT <b>Raymond S. Atkinson</b> Address <b>7224 Eastern Blvd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>501X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular Accident (2nd)</b> DUE TO (c) <b>Advanced, generalized Atherosclerosis &amp; HCVD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>3 wks</b> <b>undet</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition and electrolyte imbalance Secondary to (a) above</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 19 56</b> , to <b>Dec. 4 19 57</b> , that I last saw the deceased alive on <b>Dec 3 1957</b> , and that death occurred at <b>9:15 p. M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>7527 Belair Rd Balto 6 Md</b> DATE SIGNED <b>Dec 6 57</b>			
ACTUAL SIGNATURE <b>John C. Hyle</b>		M.D. <b>7527 Belair Rd Balto 6 Md</b>	
PHYSICIAN'S NAME (Type) <b>JOHN C. HYLE MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 8, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassokin Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>DEC 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Edith H. Hyle</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE A. J. COOPER

1901

THE A. J. COOPER

12737 CERTIFICATE OF DEATH

12713 33  
Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <b>ROSEWOOD STATE TRAINING SCHOOL</b> <b>BALTIMORE</b>		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS Mills, Maryland</b>		c. LENGTH OF STAY IN 1b <b>16 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>ROSEWOOD STATE TRAINING School</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 16, MARYLAND</b>	
f. STREET ADDRESS <b>2104 ELSINOR AVENUE</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Lynn BANNISTER</b>		4. DATE OF DEATH Month Day Year <b>12 18 1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/24/35</b>
9. AGE (In years last birthday) <b>22 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GILBERT BANNISTER</b>		14. MOTHER'S MAIDEN NAME <b>LUCILE SCHULER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>ROSEWOOD RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO-PNEUMONIA (ACUTE BRONCHITIS)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DECUBITUS ULCER OF THE SACRUM</b> DUE TO (c) <b>SPASTIC QUADRIPLÉGIA</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Microcephaly</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12/18</b> , 1957, to <b>12/18</b> , 1957, that I last saw the deceased alive on <b>12/18</b> , 1957, and that death occurred at <b>1:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rosewood Lane Owings Mills, Md.</b> DATE SIGNED <b>12/19/57</b> ACTUAL SIGNATURE <b>Ernest J. Decuo</b> PHYSICIAN'S NAME (Type) <b>ERNEST J. DECULO</b> <b>ROSEWOOD STATE TRAINING School</b>			
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>Dec. 24, 1957</b>	<b>Worthington</b>	<b>Harford Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Bailey</b>		24a. REG. BY REGISTRAR <b>Dec. 24, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>E. J. Kirdy</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12738 CERTIFICATE OF DEATH

12714

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>2</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oaklee Village</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oaklee Village</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>128 Oaklee Village</u>		d. STREET ADDRESS <u>128 Oaklee Village</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Margaret</u> Middle <u>Barber</u> Last <u></u>		<b>4. DATE OF DEATH</b> Month <u>Dec.</u> Day <u>15</u> Year <u>1957</u>	
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept. 10, 1897</u>
<b>9. AGE</b> (In years last birthday) <u>60</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>	<b>IF UNDER 24 HRS</b> Hours <u></u> Min <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Clothing</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Germany</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>---Harger</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes no, or unknown) (If yes, give war or dates of service) <u></u>		<b>16. SOCIAL SECURITY NO</b> <u>218 12 4950</u>	
<b>17. INFORMANT</b> <u>Mrs. Helen Cullen, 128 Oaklee Village</u>		Address <u></u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE PANCREAS</u> <u>107X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>THROMBOPHLEBITIS LEFT LEG</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I attended the deceased from</b> <u>OCT 10, 1956</u> , to <u>DEC 15, 1957</u> , that I last saw the deceased alive on <u>DEC 12, 1957</u> , and that death occurred at <u>5:45 A</u> M, from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>Kennard Yaffe</u>		<b>ADDRESS</b> (Street, city or town, state) <u>301 W BALTIMORE ST.</u>	
<b>PHYSICIAN'S NAME</b> (Type) <u>KENNARD YAFFE</u>		<b>DATE SIGNED</b> <u>12/17/57</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>12/17/57</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Pl.</u>		<b>22d. LOCATION</b> (City, town, or county) <b>(State)</b> <u>Baltimore</u> <u>MARYLAND</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witzke Funeral Directors, 4101 Edmondson</u>		<b>24a. REC'D BY REGISTRAR</b> <u>18 57</u>	

JOHN V. S.

1957

25



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2/57

12739 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12715  
Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c LENGTH OF STAY IN 1b <b>Timonium</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>174 Cinder Road</b>		d. STREET ADDRESS <b>174 174 Cinder Road</b>	
3 NAME OF DECEASED (Type or print) <b>MARIAN ELLEN BEARDSLEY</b>		4 DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>October 27, 1957</b>
9. AGE (In years last birthday) yrs <b>7</b> Months <b>9</b> Days <b>29</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>29</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Warren H. Beardsley</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Walsh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Warren H. Beardsley, Timonium, Maryland</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410X Upper Respiratory Infection</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>410X</b> DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>24 Hours</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/9/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>May's Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Timonium, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns</b>		ADDRESS <b>Towson, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 13 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MEDICAL CERTIFICATION

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2-44-3XL

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12740

CERTIFICATE OF DEATH

12716/5

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Y</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. LENGTH OF STAY IN 1b <b>4 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Ivy Hall, 190 Harrison Ave.</b>		d. STREET ADDRESS <b>Baltimore 1740 Fleet St.,</b>	
3 NAME OF DECEASED (Type or print) <b>Anna</b> First <b>Behr</b> Last		4. DATE OF DEATH Month <b>Dec</b> Day <b>31</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May. 9. 1873</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR: Months <b>31</b> Days <b>31</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ferdinand Schneider</b>		14. MOTHER'S MAIDEN NAME <b>Anna Woelfel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Ferdinand E. Behr. 2600 Jefferson St. Balto.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>arteriosclerotic Cardio-Vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 day</b> (c) <b>10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1, 1957</b> , to <b>Dec 21, 1957</b> , that I last saw the deceased alive on <b>Dec 31, 1957</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Banngardner M.D.</b>		DATE SIGNED <b>12/31/57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 3. 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC. Baltimore Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 6 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Edith H. Hurler</b>			



U. S. A.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The below copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1274 CERTIFICATE OF DEATH

1271740

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kingsville</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kingsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bradshaw Rd.</u>				STREET ADDRESS (If rural give location) <u>Bradshaw Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bertha</u>		(Middle) <u>S.</u>		(Last) <u>Bell</u>		(Month) (Day) (Year) <u>Dec. 5 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 22, 1878</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jarrett Standiford</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. William W. Bell Kingsville, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Pneumonia</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Cardiovascular Disease</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CVA left side paralysis</u>				<u>3 mos</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 29, 1957</u> , to <u>Dec. 5, 1957</u> , that I last saw the deceased alive on <u>Dec. 5, 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William W. Bell</u>				ADDRESS (Street, city, town, state) <u>Kingsville Md.</u>		DATE SIGNED <u>12-5-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 8, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Salem Methodist</u>		LOCATION (City, town, or county) (State) <u>Franklinville Rd. Balto. Co.</u>	
24. REC'D BY REGISTRAR <u>DEC 9 1957</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter H. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. ...</u>		ADDRESS <u>741 Balto. Rd.</u>	

U. S. A.

THE GREAT

12742 CERTIFICATE OF DEATH

12742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>55 Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>613 St. Francis Road</i>		d. STREET ADDRESS <i>613 St. Francis Road</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Edward Joseph Bennett</i>		4. DATE OF DEATH <i>December 25th 1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 24, 1900</i>
9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Builder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael Bennett</i>		14. MOTHER'S MAIDEN NAME <i>Mary Anna Schmidt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Laura Rita Bennett, 613 St. Francis</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 minutes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2 AM 12/25</i> 19 <i>57</i> , to <i>1:30 AM</i> 19 <i>57</i> , that I last saw the deceased alive on <i>12/25</i> 19 <i>57</i> , and that death occurred at <i>1:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph J. Cameron</i>		ADDRESS (Street, city or town, state) <i>1515 Martin Blvd</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH J. CAMERON</i>		M.D. <i>12/26/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/28/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>DATE</i>		24b. REGISTRAR'S SIGNATURE <i>Nebel Gray</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

NO 1 1957

RECEIVED



TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for 7 days. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12719 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN TB <u>2 YRS.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>		d. STREET ADDRESS <u>8107 ROSEBANK AVE.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8107 ROSEBANK AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE HEIM BENNETT</u>		4. DATE OF DEATH Month Day Year <u>12-24-1957</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM. BENNETT</u>		14. MOTHER'S MAIDEN NAME <u>ANNA BRAUN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>192-28-2187</u>	
17. INFORMANT Address <u>MRS. MARION STADLEY - DUNDALK, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>A-S-C-V-Disease</u> (c) <u>—</u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ALTONA, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Bradley, Dundalk, Md.</u>		24a. REG'D BY REGISTRAR <u>DEC 21</u>	
		24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. Kupper</u>	

BUREAU V

DEC 22 1957

RECORDED

12743 CERTIFICATE OF DEATH

12720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN 1b <u>5 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. STREET ADDRESS <u>RFD # 2</u>			
3. NAME OF DECEASED (Type or print) First <u>Harrison</u> Middle <u>Bishop</u> Last <u>57</u>				4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-22-02</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James L. Bishop</u>				14. MOTHER'S MAIDEN NAME <u>Maggie R Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>26-24-7</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Histoplasmosis</u> <u>134.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>12</u> <u>00</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-22-1957</u> , to <u>12-25-1957</u> , that I last saw the deceased alive on <u>12-25-1957</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William Newcomer</u> M.D. <u>Mt. Wilson, Maryland</u>				PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D., Superintendent</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 29, 1957</u>		<u>Bellair Memorial Park</u>		<u>Harford Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				24a. REG'D BY REGISTRAR DATE <u>Dec 27, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Barthelme</u>	

JOHN W. B.

17

17

## 12744 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>	
c. LENGTH OF STAY IN 1b <b>17 days</b>		d. STREET ADDRESS <b>None</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EARLE</b> Middle <b>W.</b> Last <b>BLACKBURN</b>		4. DATE OF DEATH Month <b>December 14</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/12/94</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min <b>63</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert Henry Blackburn</b>	
14. MOTHER'S MAIDEN NAME <b>Cecilia Spicer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>Yes</b> <b>WWI</b>	
16. SOCIAL SECURITY NO. <b>213-03-5873</b>		17. INFORMANT <b>Clin. Recs. Vets. Admin. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY ABSCESS</b> <b>521X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 27, 1957</b> to <b>December 14, 1957</b> that I saw the deceased alive on <b>November 27, 1957</b> and that death occurred at <b>5:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald D. Mark</b>		ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b>	
DATE SIGNED <b>12/14/57</b>		M.D. <b>VAH Fort Howard, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/17/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hiss Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24a. REC'D BY REGISTRAR <b>17 1957</b>	
ADDRESS <b>5305 Harford Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>James L. Farley</b>	

LEONARD J. RUCK FUNERAL HOME, 5305 HARFORD RD., BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12722

## , 12745 CERTIFICATE OF DEATH

Reg. Dist. No. 33

3. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>100 Berrymans Lane</b>			d. STREET ADDRESS <b>Berrymans Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>Agnes</b> Last <b>Bollinger</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>5</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1907</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Govt. Employee</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>
13. FATHER'S NAME <b>Sylvester Bollinger</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Flynn</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Michael J. Bollinger, Baltimore, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Embolism</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Phenolate heart disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>40 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>Nov 1950</b> to <b>Dec 1957</b> , that I last saw the deceased alive on <b>Nov 1957</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above					
ACTUAL SIGNATURE <b>Louis Dalmace</b>		M.D. <b>1113 Reisterstown Rd</b>		DATE SIGNED <b>Dec 6/57</b>	
PHYSICIAN'S NAME (Type) <b>Louis Dalmace</b>		<b>12401-211 8 Rd</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 9, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>12-6-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>

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12746

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>43 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>TRA</b> Middle <b>W.</b> Last <b>BOZMAN</b>				4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8, 1895</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - Accntnt</b>		11. BIRTHPLACE (State or foreign country) <b>Cape Charles, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Bozman</b>				14. MOTHER'S MAIDEN NAME <b>Sara Wallace</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I 215-07-7256</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOMEGALY WITH HYPERTROPHY AND DILATATION of RIGHT AND LEFT VENTRICLES</b> (b) <b>Due to: HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> (c) <b>UNKNOWN</b>							
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>14 YEARS</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>VA</b> o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 7, 1957</b> to <b>December 20, 1957</b> and that death occurred at <b>7:50 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chien Wei Lan</b>				M.D. <b>VAH FT. HOWARD, MARYLAND</b> DATE SIGNED <b>12/20/57</b>			
NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner</b> ADDRESS <b>North &amp; Pa. Ave Balto. Md</b>				24a. REC'D BY REGISTRAR <b>DEC 21 1957</b> 24b. REGISTRAR'S SIGNATURE <b>L. J. Harvey</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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12747 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>22 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DONALD</b> Middle <b>F.</b> Last <b>BROWN</b>				4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/21/33</b>	9. AGE (In years last birthday) <b>24</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oilier-Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nolan S. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Anna Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>PL-28 216-30-5855</b>		17. INFORMANT <b>Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NEOPLASM, METASTATIC</b> <b>178x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EMBRYONAL CARCINOMA LEFT TESTICLE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>16 MONTHS</b> <b>18 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that <b>VA</b> attended the deceased from <b>December 6, 1957, to December 28, 1957</b> and that death occurred at <b>12:40 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH Fort Howard, Md. 12/28/57</b>							
ACTUAL SIGNATURE <b>W. C. Dudley</b> M.D. <b>W. C. DUDLEY, M.D.</b>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-31-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b>				24a. REC'D BY REGISTRAR DATE <b>12/30/57</b>		24b. REGISTRAR'S SIGNATURE <b>Hanson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

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12748

## CERTIFICATE OF DEATH

127253 3

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN TB <u>10 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chromie Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HESTER</u> Middle <u>V.</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Brown</u>		14. MOTHER'S M.A.DEN NAME <u>Mary Meyers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Bessie A. Nelson Chromie Rd Reisterstown</u>	
17. INFORMANT <u>Bessie A. Nelson Chromie Rd Reisterstown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>Years</u> <u>Years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 1956</u> to <u>December 25, 1957</u> that I last saw the deceased alive on <u>December 24, 1957</u> and that death occurred on <u>3:30 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u> DATE SIGNED <u>Dec 25, 1957</u>	
PHYSICIAN'S NAME (Type) <u>CLARENCE E. MCWILLIAMS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-28-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 30 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary E. Long</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12749 CERTIFICATE OF DEATH

127268

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>18 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		e. STREET ADDRESS <b>54 S. FULTON AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>BROWNING</b> Last <b>BROWNING</b>		4. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>1957</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-04</b>
9 AGE (In years last birthday) <b>53</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER, CITY OF BALTO.</b>	
11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE BROWNING</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH MANGRUM</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <b>213-03-8884</b>	
17 INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> <b>102X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>240 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-6-1955</b> to <b>12-24-1955</b> ; that I last saw the deceased alive on <b>12-24-1955</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>12-24-55</b>			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> <b>Superintendent</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-27-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>A. A. Co., Md.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>WITZKE FUNERAL DIR. EDMONDSON</b>		24a. REC'D BY REGISTRAR <b>DATE 12/27/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Donnelly Newell</b>			

BUREAU V. S.

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## 12750 CERTIFICATE OF DEATH

12727 38  
Reg. Dm. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTY.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>435 E. PENNA. AVE</u>		d. STREET ADDRESS <u>435 E. PENNA. AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRIETT E. BUCHANAN</u>		4. DATE OF DEATH Month Day Year <u>12 5 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1904 MAR. 7. 1911</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILY</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ALBERT WILSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>21414087</u>	
17. INFORMANT <u>REGINA WILSON</u>		Address <u>437 E. PENNA. AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular hemorrhage</u> DUE TO (b) <u>Generalized arteriosclerosis &amp; hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>8 WKS 4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOV 15</u> , 19 <u>56</u> to <u>DEC 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>OCT 6</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T. C. Siwinski</u>		ADDRESS (Street, city or town, state) <u>17 W. Penna. Ave</u>	
PHYSICIAN'S NAME (Type) <u>T. C. SIWINSKI</u>		DATE SIGNED <u>DEC 6, 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>	22d. LOCATION (City, town, or county) (State) <u>Towson, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Am. Undertaking - 1701 77th Calhoun St</u>		24a. REC'D BY REGISTRAR <u>DATE 9 100</u>	
ADDRESS <u>Baltimore, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Michael Guy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12751

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>		d. STREET ADDRESS <u>1308 Linden Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry M BUCKEY</u>		4. DATE OF DEATH Month Day Year <u>Decemb. 15 1957</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-15-82</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL. SERV.</u>	
11. BIRTHPLACE (State or foreign country) <u>LIBERTY TOWN/MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John W. BUCKEY</u>		14. MOTHER'S MAIDEN NAME <u>Radcliffe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>RECORD</u>		Address <u>Spring Grove State Hosp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT</u> 20 min <u>160X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>GENERAL ARTERIOSKLEROSIS</u> 8 years DUE TO (c) <u>DIABETES</u> 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14</u> , 19 <u>53</u> , to <u>12/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>57</u> , and that death occurred at <u>7 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Spring Grove State Hosp. 12/15/57</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		<u>Catonville 28 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-19-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Howard Strong</u>		ADDRESS <u>3001 North Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 1957

## 12723 CERTIFICATE OF DEATH

12723 42

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1228 Maiden Choice Lane</b>		d. STREET ADDRESS <b>1228 Maiden Choice Lane</b>	
3. NAME OF DECEASED (Type or print) <b>MADORA BULLOCK</b>		4. DATE OF DEATH <b>12-22-57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 14, 1893</b>
9. AGE (In years last birthday) <b>64</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>22</b> Hours <b>57</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Stroll Pond, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Isaac Dwyer</b>		14. MOTHER'S MAIDEN NAME <b>Susan Apsley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Rhoda Brooks</b>		Address <b>1223 Maiden Choice Lane</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>4 a.m.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary vascular disease</b> DUE TO (c) <b>Semilethal</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> 19 <b>Dec 22</b> 19 <b>57</b> that I last saw the deceased alive on <b>Dec 1</b> 19 <b>57</b> , and that death occurred at <b>7 P</b> M, from the causes and on the date stated above.			
SIGNATURE <b>Geo. S. M. Kieffer</b> M.D.		ADDRESS (Street, city or town, state) <b>1010 Lead</b> DATE SIGNED <b>Dec 23 1957</b>	
PHYSICIAN'S NAME (Type) <b>GEO. S. M. KIEFFER M.D.</b>		<b>Baltimore</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-26-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave</b>	
24a. REC'D BY REGISTRAR <b>DEU</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Geo. S. M. Kieffer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 27 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12716 CERTIFICATE OF DEATH

1273047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2120 WILLOW SPRING RD</b>		d. STREET ADDRESS <b>2120 WILLOW SPRING RD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JACOB WILLIAM BURKETT</b>		4. DATE OF DEATH Month Day Year <b>12-24-57 19</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR 15, 1909 48</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTR. FIRMS</b>	
11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACOB W. BURKETT, SR.</b>		14. MOTHER'S MAIDEN NAME <b>LILY (DNK)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>119-01-3054</b>	
17. INFORMANT <b>Kathleen M. Burkett</b> Address <b>Sam</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes mellitus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>about 5 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>November 1957</b> to <b>December 24/57</b> that I last saw the deceased alive on <b>December 24/57</b> and that death occurred at <b>5:30 A.M.</b> the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>12724/57</b> DATE SIGNED <b>12/24/57</b>			
MEDICAL CERTIFICATION DEATH SIGNATURE <b>J. H. Thomas</b> M.D.		PHYSICIAN'S NAME (Type) <b>J. H. Thomas</b> <b>107 N. Main St. Balto 22 MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/28/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OAK LANE</b>	22d. LOCATION (City, town, or county) <b>BALTO. CO. MD</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dink Shockey, Dundalk, Md.</b> ADDRESS _____		24a. REC'D BY REGISTRAR <b>DEC 27 1957</b>	24b. REGISTRAR'S SIGNATURE <b>W. M. Fisher</b>

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DEC 04 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812731  
12752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN <b>Ruxton</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ruxway Home 7912 Ruxway Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ruxton 4</b> d. STREET ADDRESS <b>7912 Ruxway Road</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES J. BURNS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1918</b>
9. AGE (in years) <b>39</b> yrs		10. UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	11. UNDER 24 HRS Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conval. Home Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>077-12-6976</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet Wound in Head</b> <b>476X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Sudden</b> (a), stating the underlying cause last, (c) <b>Sudden</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12/21/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec/23, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>		ADDRESS <b>Towson, Md.</b>	
24a. REC'D BY REGISTRAR <b>Dec. 23, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

BUNIAU V. S.

1937

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RECEIVED

12753

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth16dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Melvin</b> Last <b>Campbell</b>		4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Jasper Newton</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Barger</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 21</b> , 19 <b>57</b> , to <b>Dec. 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 11</b> , 19 <b>57</b> , and that death occurred at <b>3:30a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louie Frances Woodward</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>12-11-57</b>	
PHYSICIAN'S NAME (Type) <b>Louie Frances Woodward, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 14, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	22d. LOCATION (City, town, or county) (State) <b>Bel Air Harford Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard McCombs</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 19 57</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur Smith</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
DEC 19 1957

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12733

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Point Blvd. and Eastern Ave.</u>		d. STREET ADDRESS <u>306 North Point Road</u>	
3. NAME OF DECEASED (Type or print) <u>Perino (Peter)</u> First Middle Last		4. DATE OF DEATH <u>Dec. 8 1957</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taylor</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturer</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Albert Campelli</u>	
14. MOTHER'S MAIDEN NAME <u>Anna M. Bonarentera</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>213-05-9430</u>		17. INFORMANT <u>Clementine Campelli</u> Address <u>128 S. Bouldin St. #24</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Cervical Spine</u> <u>Compound Fracture of Tibia &amp; Fibula at Ankle</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Fracture at Ankle</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Shock by Auto on N. Pt. Blvd at Eastern Ave</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shock by Auto on N. Pt. Blvd at Eastern Ave</u>	
20c. TIME OF INJURY <u>2:40</u> a.m. <u>11/8/57</u>		20d. INJURY OCCURRED <u>While at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. CITY OR TOWN <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		DATE SIGNED <u>11/8/57</u>	
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 11, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Brudzinski</u>		24a. REC'D BY REGISTRAR <u>DEC 11 1957</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

U. S. A.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2 57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12734 *42*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>BALTO</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>5554 Link ave</i>		d. STREET ADDRESS <i>5553 Link ave</i>	
3. NAME OF DECEASED (Type or print) <i>Blanche P Carback</i>		4. DATE OF DEATH Month <i>12</i> Day <i>26</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 6 1888</i>
9. AGE (in years and birthday) <i>69</i> yrs		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>usa</i>	
13. FATHER'S NAME <i>William T Houck</i>		14. MOTHER'S MAIDEN NAME <i>Mollie E (Tintum)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mr Carback</i>		Address <i>5553 Link ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> a. m. <i>0</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Geo M Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>C E O S. M. RIEFFER MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>Dec 28 57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/30/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ambron Inc. 1326 Lakeside Spring Rd.</i>		24a. REC'D BY REGISTRAR <i>DEC 30 1957</i>	
24b. REGISTRAR'S SIGNATURE <i>Geo M Kieffer</i>			

RECEIVED

DEC 30 1957

BUREAU V. S.



12755

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. LENGTH OF STAY IN 1b <b>3 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PARADISE NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDITH L CARPENTER</b>				4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-14-77</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Daniel Lambdin</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Geoghigan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Margaret Sherrick, Paradise Nursing Home</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerosis Generalized</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/1/57</b> , 19____, to <b>12/14/57</b> , 19____, that I last saw the deceased alive on <b>12/13/57</b> , 19____, and that death occurred at <b>4:45 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. Mc Grath M.D.</b>				ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28md</b>		DATE SIGNED <b>12/14/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grace Church</b>	
22d. LOCATION (City, town, or county) (State) <b>Taylors Island Md.</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Home, Cambridge, Md.</b>			
24a. REC'D BY REGISTRAR <b>DEC 16 57</b>				24b. REGISTRAR'S SIGNATURE <b>Reed Smith</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 10 1900

RECEIVED  
JAN 10 1900

12756 CERTIFICATE OF DEATH

12736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Id.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore suburbs</b>		c. LENGTH OF STAY IN TB <b>7 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>7044 Eastbrook Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. NAME OF HOSPITAL (If not in hospital, give street address) <b>7044 Eastbrook Ave.</b>		d. STREET ADDRESS <b>506 S. Streeper St.</b>	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>CARROLL</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1. 1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>81</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fire Dept. Balto. City. Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Carroll</b>		14. MOTHER'S MAIDEN NAME <b>Mary Fields</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Frances Carroll (wife)</b>		Address <b>506 S. Streeper</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August</b> <b>1957</b> , to <b>Dec. 2</b> <b>1957</b> , that I last saw the deceased alive on <b>Dec. 1</b> <b>1957</b> , and that death occurred at <b>9 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2739 Eastern Ave. Balto. Md.</b> DATE SIGNED <b>12/2/57</b>			
ACTUAL SIGNATURE <b>Eugene Zeller, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Eugene Zeller, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 5, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC.</b>		ADDRESS <b>Baltimore Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 4 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. Kelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 7 1977

RECEIVED

## 12757 CERTIFICATE OF DEATH

12737

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>68 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
f. STREET ADDRESS <b>228 North Gilmore Street</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>E.</b> Last <b>COLBURN</b>				4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>May 3, 1913</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b>14</b> Min <b>14</b>		IF UNDER 24 HRS. Months <b>11</b> Days <b>14</b> Hours <b>14</b> Min <b>14</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Spotter &amp; Presser</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Harry Colbourn</b>				14. MOTHER'S MAIDEN NAME <b>Merle Muir</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO <b>214-14-4040</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>THROMBOSIS OF BASILAR ARTERY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b). DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>ACUTE AND CHRONIC PANCREATITIS - Duration Unknown</b> <b>Operation - 12-2-57 Splenectomy - Necrosis of tail of pancreas</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>October 2, 1957</b> , to <b>December 9, 1957</b> , and that death occurred at <b>9:05 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>12/10/57</b>							
ACTUAL SIGNATURE <b>Chien Wei Lan</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>December 13, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Enroy O. Wilson, 1000 Brantley Ave., Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>12/13/57</b>		24b. REGISTRAR'S SIGNATURE <b>Newton L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. CIVIL

NO. 1057

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12759 CERTIFICATE OF DEATH

12738

33

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Butler</u>		LENGTH OF STAY (in this place) <u>40 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Butler</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Rd.</u>				STREET ADDRESS (If rural give location) <u>Falls Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>Gertrude</u> (Last) <u>Cole</u>				(Month) <u>Dec.</u> (Day) <u>19</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>9-29-1879</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Plan. Com</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Abijah Cole</u>				14. MOTHER'S MAIDEN NAME <u>Abarilla Tracey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mary E. Mallonee, Butler, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>18 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardio-Vascular Disease</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>Dec.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec.</u> , 19 <u>57</u> , and that death occurred at <u>7</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Mary E. Soudel</u>		ADDRESS (Street, city, town, state) <u>M.D. 48 Main St. Reisterstown, Md.</u>		DATE SIGNED <u>12-19-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-21-57</u>		NAME OF CEMETERY OR CREMATORY <u>St. Pauls Lutheran</u>		LOCATION (City, town, or county) (State) <u>Arcadia, Md.</u>	
24. REC'D BY REGISTRAR <u>6-20-1957</u>		REGISTRAR'S SIGNATURE <u>Mary E. Soudel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		ADDRESS <u>Towson 4, Md</u>	

BUREAU V. S.

RECEIVED  
JAN 10 1900



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12758 CERTIFICATE OF DEATH

127344  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Howard</b>				c. LENGTH OF STAY IN 1b <b>38 Days</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>505 South Luzerne Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>G.</b> Last <b>CHES</b>				4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1957</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>March 27, 1921</b>	9. AGE (In years last birthday) <b>36</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>		11 BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John J. Ches</b>				14 MOTHER'S MAIDEN NAME <b>Helen Golombiewski</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> <b>WW II</b>		16 SOCIAL SECURITY NO <b>215-05-2226</b>		17 INFORMANT <b>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LAENNEC'S CIRRHOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS. 5 MOS.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Hour <b>19</b> Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>October 28</b> , 19 <b>57</b> , to <b>December 5</b> , 19 <b>57</b> , and that death occurred at <b>7:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 12/5/57</b>							
ACTUAL SIGNATURE <i>Irving Freeman</i>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>					
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>							
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b DATE THEREOF <b>December 9, 1957</b>	22c NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23 FUNERAL DIRECTOR'S SIGNATURE <b>Raymond Kaczorowski</b>				24a REC'D BY REGISTRAR <b>25</b>		24b REGISTRAR'S SIGNATURE <i>Newton L. Harber</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

REC 10 10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12760

## CERTIFICATE OF DEATH

12740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>35 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3023 Windsor Ave.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>R.</b> Last <b>CRAFTON</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>27</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2, 1906</b>	
9. AGE (In years last birthday) yrs. <b>51</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contracting.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Elzy Crafton.</b>				14. MOTHER'S MAIDEN NAME <b>Helen Hackler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>YES</b> <b>WW II</b>				16. SOCIAL SECURITY NO <b>579-05-3296</b>		17. INFORMANT <b>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RIGHT KIDNEY WITH METASTASIS TO BONES</b> <b>180x</b> <b>180x</b> <b>180x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>180x</b> DUE TO (c) <b>180x</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>180x</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <b>VA</b> attended the deceased from <b>November 22, 19 57</b> to <b>December 27, 19 57</b> and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b> DATE SIGNED <b>12/26/57</b>							
ACTUAL SIGNATURE <b>Chien Wei Ian</b> M.D.							
PHYSICIAN'S NAME (Type) <b>CHIEN WEI IAN, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-31-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>5501 Frederick Ave., Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight</b> ADDRESS <b>6009 Harford Road</b>				24a. REC'D BY REGISTRAR <b>DATE 12/31/57</b>		24b. REGISTRAR'S SIGNATURE <b>Hanson L. Tarter</b>	

Wm Cook-Blight, 6009 Harford Road, Baltimore 14, Md.

BUENOS V. S.

DEC 31

1951

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12761 CERTIFICATE OF DEATH

Reg. Dist. No. 1274144

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>6 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>Box 511, Rt. 2</b>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>V.</b> Last <b>CULVER</b>				4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1896</b>	9. AGE (In years last birthday) yrs. <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building construction Baltimore, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles E. Culver</b>				14. MOTHER'S MAIDEN NAME <b>Emma Marshall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-07-9273</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH METASTASES TO LIVER</b> <b>151X</b> <b>DEEP AND ABDOMINAL LYMPH NODES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>UNKNOWN</b>							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation-Gastrectomy (partial) with gastrojejunostomy-Johns Hopkins Hospital-Recent.</b>							19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VA</b>		(County) (State)	
21. I certify that I attended the deceased from <b>December 5, 1957</b> to <b>December 11, 1957</b> and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>12/12/57</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b> ADDRESS <b>6009 Harford Rd., Balto. 14, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>12/18/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FURNACE V. S.

DEC 1

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JAN 1 1960

12717 CERTIFICATE OF DEATH

12742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1732 Brookview Rd. #22</b>		d. STREET ADDRESS <b>1732 Brookview Rd. #22</b>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>E.</b> Middle <b>CUMMINS</b> Last		4. DATE OF DEATH <b>December 29, 1957.</b> Month <b>December</b> Day <b>29</b> Year <b>1957.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 5, 1883</b> 9. AGE (In years lost, birthday) <b>74</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John J. Smith</b>	
14. MOTHER'S MAIDEN NAME <b>Susan Bozman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edward H. Cummins Sr.</b> Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>YEARS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATELY</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3 DEC</b> , 19 <b>57</b> , to <b>24 DEC</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>29 DEC</b> , 19 <b>57</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>33 DUNDALK AVE BALTO 22 Md</b> DATE SIGNED <b>1-1-57</b>			
ACTUAL SIGNATURE <b>W.E. BAERMANN</b> M.D.		PHYSICIAN'S NAME (Type) <b>W.E. BAERMANN, MD BALTO 22 Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-2-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>7225 EASTERN BLVD., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Geiler</b> ADDRESS <b>901 S. CONKLING ST. BALTO, 24, MD</b>		24a. REC'D BY REGISTRAR <b>1/2/58</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. Kelly</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 3 1  
BUREAU V. S.



## 12762 CERTIFICATE OF DEATH

12743

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. George</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>5814 QUINTANA STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MALCOLM</b> First <b>CHARLES</b> Middle <b>DAUGHERTY</b> Last				4. DATE OF DEATH Month <b>12</b> - Day <b>25</b> - Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-6-99</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSES - SELF</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES W. DAUGHERTY</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET GIEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>UNKNOWN</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6-28-1956</b> to <b>12-25-1957</b> , that I last saw the deceased alive on <b>12-25-1957</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b>				DATE SIGNED <b>12-25-57</b>			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>				Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<b>Burial</b>		<b>12/28/57</b>		<b>Port Lincoln Cemetery</b>		<b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>12-25-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>							

BUREAU V. S.

DEC 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12763 CERTIFICATE OF DEATH

12744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL—PHOENIX</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/RURAL—PHOENIX MD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHILPOT ROAD</b>		e. STREET ADDRESS <b>PHILPOT ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>MILTON</b> Middle <b>E.</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>?</b>
9. AGE (In years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Milton Davis</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Mary Dashiell</b>		Address <b>4202 Roland Ave. Balto. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cor pulmonale</b> DUE TO (c) <b>asthma and chronic bronchitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August, 1957</b> to <b>Dec</b> , 1957, that I last saw the deceased alive on <b>12 December, 1957</b> , and that death occurred at <b>2:55 AM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>David H. Marine</b>		DATE SIGNED <b>1733 BULTON ST. BALTIMORE 17</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Dec. 18, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>	22d. LOCATION (City, town, or county) (State) <b>Lt. Airy, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		ADDRESS <b>1900 Eutaw Pl. Balto.</b>	
24a. REC'D BY REGISTRAR <b>DEC 18 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Ely Gorsch</b>	

BUREAU V. S.

DEC 7

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12764 CERTIFICATE OF DEATH

12743/1  
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>	c. LENGTH OF STAY IN 1b <u>3 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Randallstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>13506 Chapman Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Christian</u> Middle <u>M.</u> Last <u>Delker</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 3, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H. K. Wood Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles M. Delker</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Easter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>215-109672</u>	
17. INFORMANT <u>Florence A. Delker</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY CONGESTION</u> <u>4 days</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002X</u> (b) <u>MYOCARDIAL FAILURE</u> DUE TO (c) <u>C-V DISEASE &amp; ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>6 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS ANT CAEXIA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 30</u> , 19 <u>57</u> , to <u>Dec. 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 2</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Donald H. Weinberg</u> M.D. <u>8821 LIBERTY ROAD</u> PHYSICIAN'S NAME (Type) <u>HAROLD H. WEINBERG M.D.</u> <u>RANDALLSTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec. 6, 1957</u>	<u>London Park Cem.</u>	<u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Bijers</u>		24a. REC'D BY REGISTRAR <u>DEC 13 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mr. M. Marting</u>
ADDRESS <u>8728 Liberty Road</u>			
<u>Randallstown, Md.</u>			

BUREAU V. S.

DEC 1 1900

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

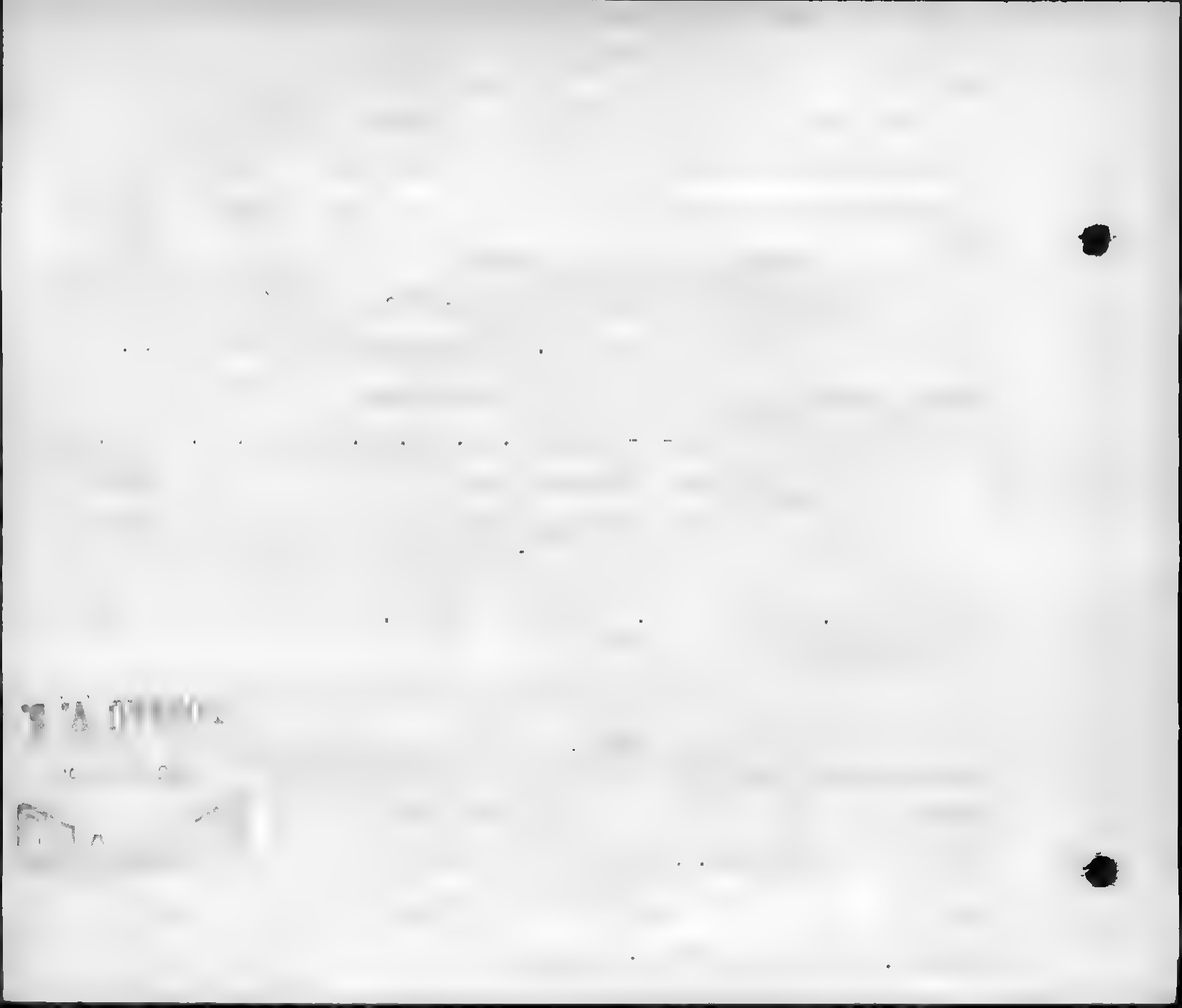
12746

## 12765 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1805 Penrose Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>OSCAR</b> Middle <b>--</b> Last <b>DICKEY</b>				4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1895</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Lynchburg, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Nelson Dickey</b>				14. MOTHER'S MAIDEN NAME <b>Tina McGill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I 213-09-3901</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, LEFT</b>							<b>UNKNOWN</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHOPNEUMONIA, BILATERAL</b>							<b>UNKNOWN</b>
(c) <b>DUE TO</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Operations: 1. Tracheostomy 2. Bilateral trephining. Date 12/6/57							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>441X</b>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>December 5, 19 57, to December 12, 19 57</b> and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chien Wei Lan</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>12/12/57</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-17-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>				ADDRESS <b>Charles R. Law Mortuary 802-04 Madison Ave Balto. Md</b>		24a. REC'D BY REGISTRAR DATE <b>12/16/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Ransom L. Farley</b>							





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12766 CERTIFICATE OF DEATH

12747

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville Rural</u> c. LENGTH OF STAY IN 1b <u>62 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belair Road Kingsville, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville Maryland Rural</u> d. STREET ADDRESS <u>Belair Road Kingsville, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary M. Dilworth</u>				4. DATE OF DEATH Month Day Year <u>12 14 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/1874</u>	9. AGE (In years lost birthday) <u>83</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gilpin O. Hutton</u>				14. MOTHER'S MAIDEN NAME <u>Frances M. Kirk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Mr. Carl B. Temple Kingsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Cardiomyopathy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>20 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Nov. 1, 1936</u> , to <u>12-14, 1957</u> , that I last saw the deceased alive on <u>12/14, 1957</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>			ADDRESS (State, city or town, state) DATE SIGNED <u>Fork Md.</u>				
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>			<u>FORK, MD.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Kingsville, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laurel Funeral Home</u>			ADDRESS <u>740 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>DEC 19 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. W. Hammett</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 19 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12767 CERTIFICATE OF DEATH

Reg. Dist. No. 12748

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>84y.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>401 Oak Forest Ave</u>		e. STREET ADDRESS <u>401 Oak Forest Ave</u>	
3. NAME OF DECEASED (Type or print) <u>LILLIE</u> First <u>DONOVAN</u> Middle <u>LOST</u> Last		4. DATE OF DEATH <u>12/28</u> Month <u>1957</u> Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 1, 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ireland</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Maguire</u>		14. MOTHER'S MAIDEN NAME <u>Mary Abbott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Mr. Mrs. Sherwood - (same)</u>	
17. INFORMANT <u>Mr. Mrs. Sherwood - (same)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Artery Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1957</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October, 1957</u> , to <u>Dec 28, 1957</u> , that I lost saw the deceased alive on <u>Dec 28, 1957</u> , and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>J. Nelson McKay</u> M.D. <u>6014 Edmonson Ave Balto 28 Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. Nelson McKay M.D.</u>		<u>6014 Edmonson Ave. Balto. 28 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12/31/57</u>	<u>Landon Park</u>	<u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nabbs &amp; Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>DEC 31</u> 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1950

RECEIVED

12768

## CERTIFICATE OF DEATH

12749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>4yrlmth12dys</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C. Hillside</b>				d. STREET ADDRESS <b>1108 - 58th Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Archie</b> Middle <b>Nelson</b> Last <b>Dorsey</b>				4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1899</b>	9. AGE (In years last birthday) <b>58</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>construction worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>W. J. Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Anderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-9172</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Infarctive myocardial fibrosis</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Regional ileitis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Oct. 17</b> , 19 <b>57</b> , to <b>Dec. 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 27</b> , 19 <b>57</b> , and that death occurred at <b>3:15a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>12-27-57</b>							
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>					
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/30/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. N. W. Washington</b>		ADDRESS <b>1901-14th</b>	24a. REC'D BY REGISTRAR <b>DEC 30 57</b>	24b. REGISTRAR'S SIGNATURE <b>DeW...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
DEC 30 1957  
BUREAU V. 2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12769 CERTIFICATE OF DEATH

Reg. Dist. No.

127588

1. PLACE OF DEATH a. COUNTY <u>Balti</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>nickville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>nickville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1309 Taylor Ave</u>		d. STREET ADDRESS <u>1309 Taylor Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Paula</u> First <u>Blond</u> Middle <u>Eust</u> Last		4. DATE OF DEATH <u>12-5-57</u> Month <u>12</u> Day <u>5</u> Year <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>schuman Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Deaton Course</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Citterion</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Paula Eust</u> Address <u>1305 Taylor Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 OCT</u> , 19 <u>57</u> , to <u>25 DEC</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 DEC</u> , 19 <u>57</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Loch R. Shopping Center</u> M.D. <u>Baltimore 12, Md.</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
<u>Loch R. Shopping Center</u>		<u>DEC 31 1957</u> <u>Loch R. Shopping Center</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

127770

Item 7 81-10223 12-24-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

12751

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>297 Montrose Avenue</b>				d STREET ADDRESS <b>297 Montrose Ave.</b>			
3 NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>JAMES</b> Last <b>EKR</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> , Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8 DATE OF BIRTH <b>Sept. 14, 1876</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cooper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kimble-Tyler</b>		11 BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>213-01-3105A</b>		17 INFORMANT <b>Frank Ekr, son, above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Cardio Vascular Renal disease</b> DUE TO (c) <b>1 yr</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Nat white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Nov 1</b> , 19 <b>57</b> to <b>Dec 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec 14</b> , 19 <b>57</b> , and that death occurred at <b>10 A</b> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. M. Baumgardner</b> M.D.			ADDRESS (Street, city or town, state) <b>Baltimore Md</b>		DATE SIGNED <b>12/17/57</b>		
PHYSICIAN'S NAME (Type) <b>G. M. Baumgardner, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/17/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
23 FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, Inc.</b> <b>2601 E. Madison St.</b>			24a REC'D BY REGISTRAR <b>DEC 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 2 1950

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12771

## CERTIFICATE OF DEATH

12752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>				c. LENGTH OF STAY IN 1b <b>4 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>520 Morris Ave.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>			
f. STREET ADDRESS <b>520 Morris Ave.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ethel Morgan Elliott</b>				4. DATE OF DEATH <b>Dec 1 1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-24-1912</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR: Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1957</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harry T. Elliott</b>		14. MOTHER'S MAIDEN NAME <b>Eva Shepperd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>215-05-2052</b>		17. INFORMANT <b>Mrs. Virginia Einstein, 201 N. Beechwood</b>		Address <b>Balto. 28, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the ovary</b> <b>175x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>June, 1957</b> to <b>Dec. 1, 1957</b> , that I last saw the deceased alive on <b>Dec. 1, 1957</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. M. France</b> M.D.				ADDRESS (Street, city or town, state) <b>Parkton, Md.</b> DATE SIGNED <b>12/1/57</b>			
PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-4-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. James Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>Monkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>				ADDRESS <b>622 York Rd., Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE DEC 3 '57</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

RECEIVED  
JAN 10 1968  
U. S. AIR FORCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12772 CERTIFICATE OF DEATH

12753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4211 Darnell Ave.</u>		d. STREET ADDRESS <u>118 N. Port St.</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>F.</u> Last <u>ELLOFF</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1905</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Emil Radke</u>		14. MOTHER'S MAIDEN NAME <u>Atherinn Neiberding</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		
17. INFORMANT <u>William Elloff - 118 N. Port St.</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Infarction</u> <u>45X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerosis Cardio Vascular Disease</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u> <u>3</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Urinary tract Infection</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <u>11-15, 1957</u> to <u>12/3, 1957</u> that I last saw the deceased alive on <u>12-3, 1957</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>Paul G Mueller</u>		ADDRESS (Street, city or town, state) <u>6331 Belair Rd</u>		
DATE SIGNED <u>DEC 6 1957</u>				
PHYSICIAN'S NAME (Type) <u>PAUL G MUELLER M.D.</u>		<u>Balt 6 Md</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>
22d. LOCATION (City, town, or county) <u>Parkville, Md.</u>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Smith</u>

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12754

12773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6836 Dogwood Road</u>				d. STREET ADDRESS <u>16836 Dogwood Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>George E. Euler</u>				4. DATE OF DEATH Month Day Year <u>Dec. 19, 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Schirner (Chas)</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Euler</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Younger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-63-0798</u>		17. INFORMANT Address <u>Mrs. Viola Euler-6836 Dogwood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic arthritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>14 Feb</u> , 19 <u>57</u> , to <u>12 Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 Dec</u> , 19 <u>57</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles W. Williams,</u> M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED	
NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 21, '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>				ADDRESS <u>6411 Windsor Mill Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 20 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. C. Martin</u>			

BUREAU OF

NOV 28 1967

RECEIVED



. 12774

## CERTIFICATE OF DEATH

Reg. Dist. No. 12755

1 PLACE OF DEATH o COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c LENGTH OF STAY IN 1b <b>3mths13dys</b>			
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e STREET ADDRESS <b>Phoenix, Maryland</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edna Pearl Evans</b>				4. DATE OF DEATH Month Day Year <b>Dec 15 1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1887 Dec. 4, 1887</b>	
9. AGE (In years last birthday) <b>30 69 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife, retail work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Henry Fisher Wm. Harrison Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Pierce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO <b>214-14-0406</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 424.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Decompensated Cardiovascular illness</b> 23 days DUE TO (c) <b>advanced arteriosclerotic, generalized cond.</b> unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic brain syndrome due to arteriosclerosis, Parkinson's syndrome</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Nov. 7, 1957</b> to <b>Dec 15, 1957</b> , that I last saw the deceased alive on <b>Nov. 30, 1957</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gertrude J. Fleischmann</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL Dec 15 1957</b>			
PHYSICIAN'S NAME (Type) <b>GERTRUDE J. FLEISCHMANN Catonsville 28, Maryland</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-3-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Episcopal Grave</b>		22d. LOCATION (City, town or county) (State) <b>Catonsville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brookes Funeral Service 622 York Rd</b>				24a. REC'D BY REGISTRAR <b>5</b>		24b. REGISTRAR'S SIGNATURE <b>Edna Evans</b>	

RECEIVED V. S.

1904

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12775 CERTIFICATE OF DEATH

12756  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>6 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>FORREST HAVEN NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>MARIE</b> Last <b>FANNING</b>		4. DATE OF DEATH Month <b>12</b> Day <b>31</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 16, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK FANNING</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH KITTRICK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. ROSE STURDEVANT,</b>		<b>5507 EDMONSON AVE. CATONSVILLE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parkinsons Disease</b> <b>3000X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
21. I certify that I attended the deceased from <b>12/23</b> , 19 <b>57</b> , to <b>12/31</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/30</b> , 19 <b>57</b> , and that death occurred at <b>12:45</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>BALTIMORE 29, MD.</b> DATE SIGNED <b>12/31/57</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <b>E. F. [Signature]</b> M.D.		PHYSICIAN'S NAME (Type) <b>FRED W. KRAISS</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-4-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>FRED W. KRAISS</b>		24. REGISTAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN A. B. 1900

1900

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12776

127574

Reg. Dist. No

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4303 Soth Avenue</b>		4. STREET ADDRESS <b>4303 Soth Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CHARLES</b> Last <b>FARMER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>Dec. 27, 1888</b>	9. AGE (In years last birthday) <b>68</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Beer Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Farmer</b>		14. MOTHER'S MAIDEN NAME <b>Eupha Maxwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-2470</b>	
17. INFORMANT <b>Miss Eupha R. Muller,</b>		Address <b>4303 Soth Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/10/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Ma.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Road #14</b>	
24a. REC'D BY REGISTRAR <b>DEC 17 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Walter J. Smith</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 21 1961

RECEIVED

12777

CERTIFICATE OF DEATH

12758 33

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ROSENWOOD</u> <u>ANNE</u> <u>ARUNDEL</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSENWOOD TRAINING SCHOOL</u>		d. STREET ADDRESS <u>4710 DORRIS AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>WILLIAM</u> Last <u>LEAH</u>		4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1906</u>
9. AGE (In years last birthday) <u>51</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>22</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RALPH L FERRERI</u>		14. MOTHER'S MAIDEN NAME <u>SHARLEY KERR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROSENWOOD RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diarrhea &amp; acidosis and dehydration</u> <u>one month</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>E Coli and Proteus infection</u> <u>one month</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 8</u> , 19 <u>57</u> , to <u>Dec 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 13</u> , 19 <u>57</u> , and that death occurred at <u>3:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rosenwood State Tr. School</u> DATE SIGNED <u>12/14/57</u>			
ACTUAL SIGNATURE <u>Viola B. Johns</u>		M.D. <u>Rosenwood State Tr. School</u>	
PHYSICIAN'S NAME (Type) <u>Viola B. Johns</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION City, town, or county (State)
<u>Burial</u>	<u>Dec 14 1957</u>	<u>BALTO. NAT. CEM.</u>	<u>BALTO. MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Truman Schuch</u>		ADDRESS <u>3512 Frederick Ave (29)</u>	
24a. REC'D BY REGISTRAR <u>Margoline</u>		24b. REGISTRAR'S SIGNATURE <u>Margoline</u>	

NORMAN V. S.

1940



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12758

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If inst. l'n, Res. dence before adm. sion, a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>	
c. LENGTH OF STAY IN 1b <b>27 yrs.</b>		d. STREET ADDRESS <b>Woodbine Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>401 Woodbine Ave.</b>			
3 NAME OF DECEASED (Type or print) <b>Clara Brooks Fishpaw</b>		4. DATE OF DEATH Month <b>12-6</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-2-1876</b>
9. AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>director</b>		12. KIND OF BUSINESS OR INDUSTRY <b>public schools</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Robert. Fishpaw</b>		16. MOTHER'S MAIDEN NAME <b>Laura Brooks</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO <b>none</b>	
19. INFORMANT <b>John A. Horn, 401 Woodbine Ave., Towson 4,</b>		Address <b>Md.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> DUE TO <b>Chronic De Compensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Malnutrition</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/7/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-9-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jessops Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>I. Scott Brooks</b>		24a. REC'D BY REGISTRAR <b>DATE 12/11/57</b>	24b. REGISTRAR'S SIGNATURE <b>Metel Gray</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1900

RECEIVED

12779

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto</b> <b>7</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/ Randallstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Robb Nursing Home Essex Road Balto 7</b>		d. STREET ADDRESS <b>9119 Liberty Road</b> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First <b>Georgia</b> Middle <b>Pearse</b> Last <b>Fite</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1966</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR: Months <b>3</b> Days <b>5</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto Co; Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Fite</b>		14. MOTHER'S MAIDEN NAME <b>Mary Choate</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>	
17. INFORMANT <b>Miss Kitty C. Fite</b>		Address <b>9119 Liberty Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> <b>422.2</b> DUE TO <b>Hypertensive C.O. Disease - Kidney</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Damage to Chronic Cong Heart Failure</b> (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 1, 1957</b> to <b>DEC 23, 1957</b> , that I last saw the deceased alive on <b>DEC 23, 1957</b> , and that death occurred at <b>6:00 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas E. Wilk</b>		ADDRESS (Street, city or town, state) <b>Randallstown Md</b> DATE SIGNED <b>12/25/57</b>	
PHYSICIAN'S NAME (Type) <b>Thomas E. Wilk</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>1st. Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Holbrook Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Erving Byers</b>		24a. REC'D BY REGISTRAR <b>8228 Liberty Road</b> DATE <b>2 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Edith Bailey</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2

RECEIVED

12780

## CERTIFICATE OF DEATH

12761 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN TB <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1835 White Oak Rd.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>1835 White Oak Rd.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>W.</b> Last <b>FLANNERY</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Piano Tuner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Flannery</b>		14. MOTHER'S MAIDEN NAME <b>Briget Slavin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Yes</b>	
17. INFORMANT <b>Mrs. Joseph Martin</b>		Address <b>1835 White Oak Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary, right lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-18</b> , 19 <b>57</b> , to <b>12-23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12-23</b> , 19 <b>57</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>JOSEPH SKLOVEN, M. D. 12.24.57</b> DATE SIGNED 7122 Hartford Road Baltimore 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/27/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>		ADDRESS <b>-3000 E. Baltimore St.</b>	
24a. REC'D BY REGISTRAR <b>DEC 27 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. J. M. Bacon</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A

DEC 27

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12781 CERTIFICATE OF DEATH

Reg. Dist. No. 12762

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>11 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>330 Murdock Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ella</b> Middle <b>Cecelia</b> Last <b>Brangle Flautt</b>				<b>4. DATE OF DEATH</b> Month <b>Dec.</b> Day <b>12</b> Year <b>19 57</b>			
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARITAL STATUS</b> <b>WIDOWED <input checked="" type="checkbox"/></b>		<b>8. DATE OF BIRTH</b> <b>March 10, 1877</b>	
<b>9. AGE</b> (In years last birthday) <b>80</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>George Brangle</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Eckstein</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterioscler. Cardio vas. disease</b> DUE TO (b) <b>Arteriosclerosis, gener. severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>Dec. 6</b> <b>19 57</b> , <b>to</b> <b>Dec. 12</b> <b>19 57</b> , <b>that I last saw the deceased</b> <b>olive on Dec. 12</b> <b>19 57</b> , <b>and that death occurred at</b> <b>6:45 PM</b> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> <b>DATE SIGNED</b> <b>12/12/57</b>							
<b>ACTUAL SIGNATURE</b> <b>Stella Wachslar</b> <b>M.D.</b>				<b>PHYSICIAN'S NAME</b> (Type) <b>STELLA WACHSLER</b> <b>Catonsville 28, Maryland</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12-16-1957</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>mt. Olivet Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Frederick - Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. C. E. Cline &amp; Son</b> <b>Frederick Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>12/18/57</b>		<b>24b. REGISTRAR'S SIGNATURE</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUFILE 4-1

REC 1957

RECEIVED



## 12763 CERTIFICATE OF DEATH

1276328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
c. LENGTH OF STAY IN 1b <u>LIFE</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8623 Wendell Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS <u>8623 Wendell Ave</u>			
3. NAME OF DECEASED (Type or print) <u>STP Roy</u> Middle <u>Founds</u> Last				4. DATE OF DEATH <u>Dec</u> Month <u>26</u> Day <u>1957</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13 1894</u>	9. AGE (in years last birthday) <u>63</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANUFACTURER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER - Hewlett</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>219-01-4568</u>		17. INFORMANT <u>MYRTLE Founds</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Rectum with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>June 20, 1955</u> to <u>Dec. 26, 1957</u> , that I last saw the deceased alive on <u>Dec 26, 1957</u> , and that death occurred at <u>9:25 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>6217 Hartford rd Baltimore - 14</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				DATE SIGNED <u>Dec 26</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Dec 30 - 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>	22d. LOCATION (City, town, or county) <u>BALTO MD</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F EVANS &amp; SON</u>				ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR <u>DEC 26</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

1957

RECEIVED

## 12783 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>		c. LENGTH OF STAY IN TB <b>24 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROSEWOOD STATE TRAINING SCHOOL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - ABERDEEN</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUCINDA IRENE FRANKO</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 31 1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 26, 1924</b>
9. AGE (In years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STEPHEN FRANKO</b>		14. MOTHER'S MAIDEN NAME <b>ALICE M. WRIGHT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>—</b>	
17. INFORMANT <b>ROSEWOOD RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>POSSIBLE CARDIAC FAILURE</b> <b>325.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>SECONDARY ANEMIA</b> DUE TO (c) <b>MONGOLISM</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>Unknown</b> <b>Birth</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>31 Dec</b> , 1957, to <b>31 Dec</b> , 1957, that I last saw the deceased alive on <b>31 Dec</b> , 1957, and that death occurred at <b>5 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry B. Butler</b>		DATE SIGNED <b>January 1, 1958</b>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24. REC'D BY REGISTRAR	
25. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

RECEIVED

JAN 5 1971

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12765

12784

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. NAME OF DECEASED (Type or Print) <b>ABBIE H. FRENCH</b>			2. DATE OF DEATH <b>Dec. 19, 1957</b>		
3. PLACE OF DEATH: A. <b>Baltimore, Maryland TOWSON</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Towson</b>		
B. FULL NAME OF <b>Baltimore County</b> HOSPITAL OR INSTITUTION <b>407 Donegal Drive</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Towson</b>		
c. Length of stay in Baltimore Yrs. <b>407 Donegal Drive</b> Mos. <b>407 Donegal Drive</b> Days			D. STREET ADDRESS (If rural, give location) <b>407 Donegal Drive</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>June 15, 1865</b>	9. AGE (In years last birthday) <b>92</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		
11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>			12. CITIZEN OF WHAT COUNTRY? <b>Helen Marr Walker</b>		
13. FATHER'S NAME <b>Edward Luther Hall</b>			14. MOTHER'S MAIDEN NAME <b>Helen Marr Walker</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknowns) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO <b>none</b>		
17. INFORMANT <b>Mrs. Helen M. Hall - 407 Donegal Drive</b>			ADDRESS <b>Mrs. Helen M. Hall - 407 Donegal Drive</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b> DUE TO <b>Arteriosclerotic cardio-vascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Paroxysms disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT					
IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 19, 1957</b> , that (I) (we) last saw the deceased alive on <b>Dec 17, 1957</b> , and that death occurred at <b>10:05 P</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Charles M. Kern</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS <b>6801 Belair Rd.</b>		23C. DATE SIGNED <b>Dec 20, 57.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>12/20/57</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Claremont, N.H.</b>		25. FUNERAL DIRECTOR <b>Wm. L. Vickner Sons - Balt. 17</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>Dec 24, 1957</b>		REGISTRAR'S SIGNATURE <b>Mark Gray</b>			

THIS IS A PERMANENT RECORD. PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED

DEC 22

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12785

## CERTIFICATE OF DEATH

12766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN ID <b>12yr10mths2dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
f. STREET ADDRESS <b>3926 Norfolk Avenue</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Blumenthal</b> Last <b>Friedman</b>				4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December, 1876</b>	
9. AGE (In years last birthday) <b>81?</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Russia</b>				12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>			
13. FATHER'S NAME <b>Abraham Siegel</b>				14. MOTHER'S MAIDEN NAME <b>Naomi ?</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>442.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 25, 1957</b> to <b>Dec. 13, 1957</b> , that I last saw the deceased alive on <b>Dec. 13, 1957</b> , and that death occurred at <b>6:45a M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL 12-13-57</b>							
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL 12-13-57</b>							
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Dec 13/57</b>		<b>Ohel Shalom</b>		<b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Gerinson</b>				ADDRESS <b>2nc -1124-26 W. North</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 16 '57</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

BUREAU V. S.

DEC 16 1900

RECEIVED  
FEB 10 1901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12786

## CERTIFICATE OF DEATH

Reg. Dist. No.

127674

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>				c. LENGTH OF STAY IN 1b <b>67 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Old Court Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>M.</b> Last <b>FULLER</b>				4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 24, 1894</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min <b>63</b>		IF UNDER 24 HRS Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min <b>63</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Liquor</b>		11. BIRTHPLACE (State or foreign country) <b>Lauraville, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George Fuller</b>				14. MOTHER'S MAIDEN NAME <b>Ida Barton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give war or date of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>222-01-5104</b>		17. INFORMANT <b>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b> <b>105X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>105X</b> DUE TO (c) <b>105X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>October 25, 1957</b> to <b>December 31, 1957</b> , and that death occurred at <b>4:57</b> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George Vash</b>				ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Md.</b>			
DATE SIGNED <b>12/31/57</b>							
PHYSICIAN'S NAME (Type) <b>GEORGE VASH, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Dyer</b>				ADDRESS <b>5005 K Highway</b>		24a. REC'D BY REGISTRAR <b>DATE 1/1/58</b>	
24b. REGISTRAR'S SIGNATURE <b>Hanson L. Shirley</b>							

U. S. A. DIVISION

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12787 CERTIFICATE OF DEATH

12764/1  
Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1607 Potomac Avenue</u>		d. STREET ADDRESS <u>1607 Potomac avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Leslie</u> Middle <u>Boyd</u> Last <u>Fuller</u>		4. DATE OF DEATH Month <u>December</u> Day <u>0th</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25th 1894</u> 63 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Cutter</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Glass Industry</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Winchester Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Fuller</u>		14. MOTHER'S MAIDEN NAME <u>Emma Yew</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>216-05-7215</u>	
17. INFORMANT <u>Mollie Fuller</u>		Address <u>1607 Potomac Avenue 27</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema and</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peptic Ulcers Active</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/3/57</u> , 1957, to <u>12/9/57</u> , 1957, that I last saw the deceased alive on <u>12/9/57</u> , 1957, and that death occurred at <u>1:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. N. Frederick</u> M.D.		ADDRESS (Street, city or town, state) <u>1305 Francis Ave</u> DATE SIGNED <u>12/9/57</u>	
PHYSICIAN'S NAME (Type) <u>J. N. Frederick</u>		<u>1305 Francis Avenue</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Webb Jr.</u> ADDRESS <u>205 S. Ann St.</u>		24a. REC'D BY REGISTRAR <u>Wm. Kelly</u> DATE <u>12/10/57</u> REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. REGISTER

NO. 100

U. S. A. REGISTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

12718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dundalk</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>702I 5th Ave</u>				d. STREET ADDRESS <u>702I 5th Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Peter Paul Gabriel</u>				4. DATE OF DEATH Month Day Year <u>12 - 13 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-1903</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bethl, Steel Co</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Peter Gabriel</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Agnes Gabriel</u>				Address <u>702I 5th Ave Dundalk</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan. 1957</u> to <u>12/13</u> , 1957, that I last saw the deceased alive on <u>12/13</u> , 1957, and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph R. Liberto</u> M.D.				ADDRESS (Street, city or town, state) <u>3508 BANK ST BALTO MD</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH R - LIBERTO</u>				DATE SIGNED <u>12/14/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Gabrowski</u>				ADDRESS <u>1001 Dundalk Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>12-18-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>							

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## 12788 CERTIFICATE OF DEATH

12770

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6719 Broadview Road</b>		d. STREET ADDRESS <b>6719 Broadview Road</b>	
3. NAME OF DECEASED (Type or print) First <b>George M.</b> Middle <b>Gambrill</b> Last		4. DATE OF DEATH 12 Month 6 Day 19 57	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1879</b>
9. AGE (In years last birthday) <b>78 yrs</b>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Steamfitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Gambrill</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-10-0161</b>	
17. INFORMANT <b>Calvin Gambrill</b>		Address <b>6719 Broadview Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - Bronchial</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 5</b> , 19 <b>51</b> , to <b>Dec 6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec 5</b> , 19 <b>57</b> , and that death occurred at <b>11:45 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harold H. Burns</b> M.D.		ADDRESS (Street, city or town, state) <b>115 E. Oger St. Wash, D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Harold H. Burns</b>		DATE SIGNED <b>Dec 5, 57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/9-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Butler Church Methodist Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harold H. Burns</b>		24a. REC'D BY REGISTRAR <b>DEC 10 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Anthony Newell</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. S.

DEC 1

W. A. S.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11M3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Croftonsville</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1099 West Fayette Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Georgia</b> Middle <b>E.</b> Last <b>Gilbert</b>				4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1875</b> <del>unrecorded</del>		9. AGE (In years last birthday) <b>82 385 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>unknown David Clark</b>				14. MOTHER'S MAIDEN NAME <b>Mary unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT Records: <b>SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>904.9</b> <b>Acute Cardiac Failure</b> DUE TO (b) <b>Coronary Vascular disease</b> DUE TO (c) <b>fracture right femur</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Accidental</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Had been patient at Union Hosp, brought here 6 days ago</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Jan 19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b> (County) <b>Ind</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>George M. Kieffer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REG STRAR DATE <b>DEC 17 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. H. H.</b>	

MEDICAL CERTIFICATION

U. A. H. 111111

111111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12790 CERTIFICATE OF DEATH

12772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baynesville,</b>		c. LENGTH OF STAY IN 1b <b>XO Baynesville,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1718 Yakona Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jane</b> Middle <b>Edna</b> Last <b>Glunt</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>20,</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MoVeutown, Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles E. Hinelsbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Rank</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ethel G. Childs</b>		Address <b>6305 Charles St. Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/15</b> 19 <b>57</b> , to <b>12/20</b> 19 <b>57</b> , that I last saw the deceased alive on <b>12/20</b> 19 <b>57</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8523 Loch Raven Blvd.</b> DATE SIGNED <b>12/21/57</b>			
ACTUAL SIGNATURE <b>Gordon Grau</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Gordon Grau, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 23, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mooreland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Taylor Ave. Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		24a. REC'D BY REGISTRAR <b>DEC 20 1957</b>	
ADDRESS <b>1900 Eutaw Pl.</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>	

BUREAU V. S.

DEC 20 1917

RECEIVED  
DEC 20 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12791

## CERTIFICATE OF DEATH

12773/4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>36 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
		f. STREET ADDRESS <b>1107 Carson Ct.,</b>	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>GOINS</b> Last <b>GOINS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/26/88</b>
9. AGE (In years last birthday) <b>69</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min <b>69</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cement Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Goins</b>		14. MOTHER'S MAIDEN NAME <b>Betty West</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO <b>216-18-3864</b>	
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA OF RIGHT BRONCHUS WITH</b>			
162x <b>162x</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>METASTASIS TO MEDIASTINAL LYMPH NODES</b>			
DUE TO (c) <b>UNKNOWN</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from <b>November 23, 19 57</b> to <b>December 29, 19 57</b> and that death occurred at <b>12:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		DATE SIGNED <b>12/30/57</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>		ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-3-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas E. Kelson, Jr.</b>		24a. REC'D BY REGISTRAR <b>12/31/57</b>	
ADDRESS <b>1303 Presstman St., Balto. 17, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Ransom L. Harvey</b>	

DEC 11 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12792 1277437											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2807 Laurel Wood Court</b>						d. STREET ADDRESS <b>2807 Laurel Wood Court</b>					
3. NAME OF DECEASED (Type or print) First <b>JAMIE</b> Middle <b>SUE</b> Last <b>GOODMAN</b>						4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1957</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 24 1951</b>		9. AGE (In years last birthday) <b>5</b> yrs		IF UNDER 1 YEAR Months <b>5</b> Days <b>7</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William L. Goodman</b>						14. MOTHER'S MAIDEN NAME <b>Alice Katzenstein</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>				16. SOCIAL SECURITY NO		17. INFORMANT <b>William L. Goodman</b> Address <b>None</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Brachopneumonia complicated by Aspiration of Vomitus</b>											
Conditions, if any, which gave rise to immediate cause (b) <b>None</b>											
(c) <b>None</b>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1957</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Paul F. Guerin</b>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>12/2/57</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chapel Amerys</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Burdick</b>						24a. REC'D BY REGISTRAR <b>DEC 3 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Morothy Newell</b>			

BUREAU V. S.

10 10 1907

RECEIVED  
JUN 10 1907

Handwritten signature or initials.



12793

## CERTIFICATE OF DEATH

12775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>89 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5805 Key Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis NMI GOTTESMAN</b>				4. DATE OF DEATH Month Day Year <b>December 21 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 21, 1894</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Scranton, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Ignatz Gottesman</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Simonowitz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>216-03-8603</b>		17. INFORMANT <b>Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASTROCYTOMA, BRAIN</b> DUE TO (b) <b>175X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8 Months</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Sept. 23</b> , 19 <b>57</b> , to <b>Dec. 21</b> , 19 <b>57</b> , and that death occurred at <b>11:15 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Silverie Q. Arce M.D. VAH Fort Howard, Maryland 12/21/57</b>							
ACTUAL SIGNATURE <b>Silverie Q. Arce M.D.</b> PHYSICIAN'S NAME (Type) <b>Silverie Q. ARCE, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>12/22/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Keshre-Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Reading, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Levinson</b>				24. REC'D BY REGISTRAR <b>D L Farber</b>		24b. REGISTRAR'S SIGNATURE <b>D L Farber</b>	
25. ADDRESS <b>Sol Levinson 1126 W. North Ave., Balto., Md.</b>							

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

EC 03 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12794

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12776

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17444 Land Line</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 21</u>	
c. LENGTH OF STAY IN 1b <u>0</u>		d. STREET ADDRESS <u>8545 Pulaski Highway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA ELIZABETH GONLAND</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 6, 1890</u>
9. AGE (In years, last b (th day)) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>York, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>John B. Lantz</u>		14. MOTHER'S MAIDEN NAME <u>Anna Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Dorothy R. Myers</u>		Address <u>340 W. North St, York, PA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury of chest</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause lost. (c) <u>  </u> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>How</u> <u>11:45</u> <u>o. m.</u> <u>12/22</u> <u>1957</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RT. 111</u>	20f. (City or town) (County) (State) <u>MD Line BALD.</u> <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. F. RANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/22/57</u>	
22a. BURIAL CREMATION OR REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>York, PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. COOK-TOWNSHINE</u>		24b. REGISTRAR'S SIGNATURE <u>Chester L. Fulton</u>	
ADDRESS <u>TOWSON-MD</u>		24a. REC'D BY REGISTRAR <u>  </u>	
DATE <u>12/26/57</u>			

RECEIVED

DEC 11 1954

U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

127745  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, give address) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>409 Edgewater Apts.</b>		e. STREET ADDRESS <b>LANGLEY RD</b>	
3. NAME OF DECEASED (Type or print) <b>RAYMOND HOWARD GRAHAM</b>		4. DATE OF DEATH <b>December 17, 1957</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 2, 1957</b>
9. AGE (in years last birthday) <b>6</b> yrs		10. IF UNDER 1 YEAR <b>6</b> Months <b>15</b> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BOBBY J. GRAHAM</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA H. G. HUDAK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>B. J. GRAHAM</b>		Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Interstitial Pneumonia</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/20/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Bald. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Headmaster, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 18 1957</b>	
ADDRESS <b>Walter Brooks Bradley, Headmaster, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Turley</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1944

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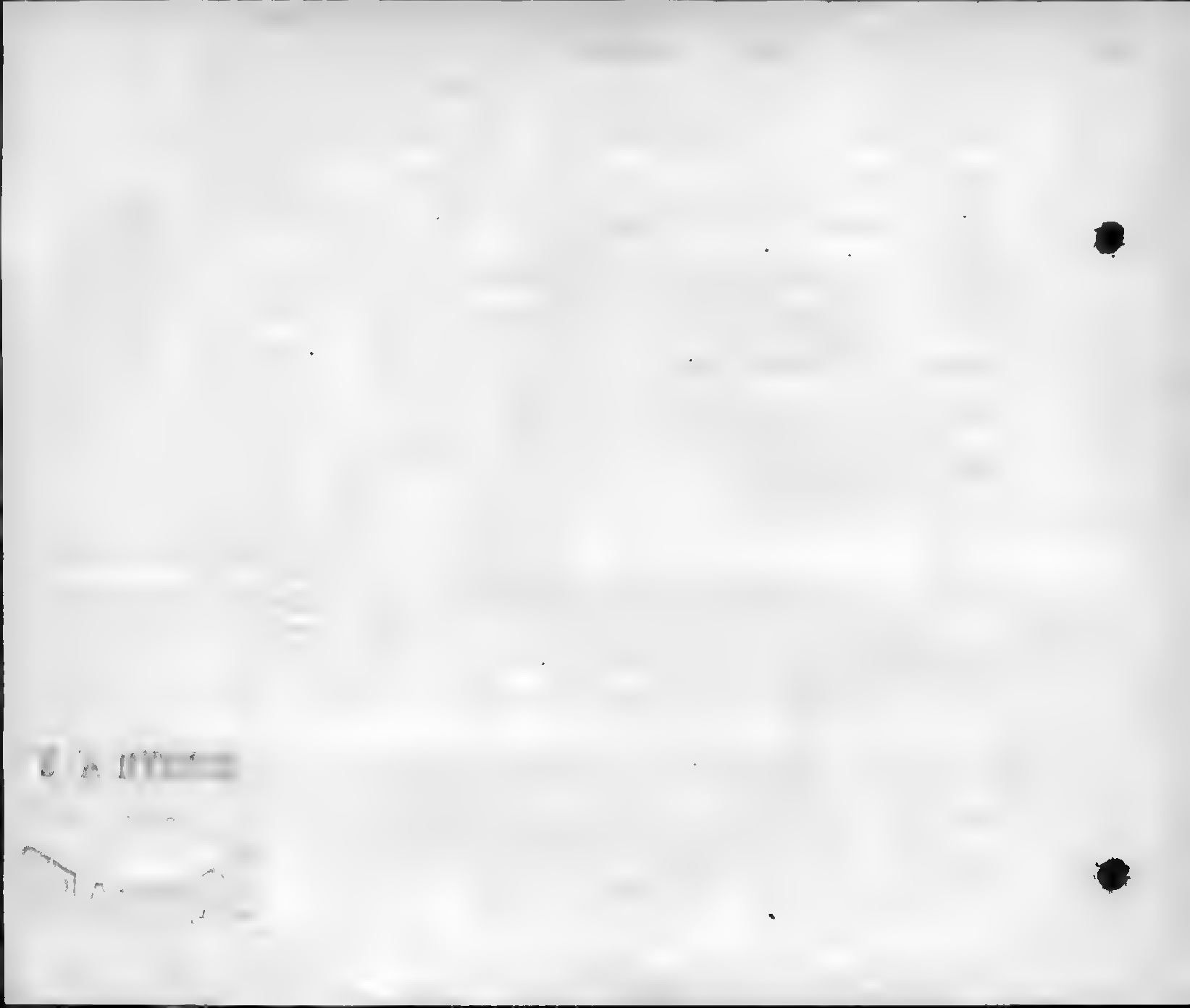
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the medical examiner. TO THE CHIEF MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reburial.

VS. A13ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12778 12796 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>846 OAKLEIGH BEACH AVE.</b>				e. STREET ADDRESS <b>846 OAKLEIGH BEACH AVE</b>			
3. NAME OF DECEASED (Type or print) <b>ELEANORA F. GRANVILLE</b>				4. DATE OF DEATH <b>12/11/1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 14 1904</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MIXER = Poplar</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO - MD.</b>		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>NOT KNOWN</b>				14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>GED C. JR.</b> Address <b>846 OAKLEIGH BEACH AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M B Davis MD</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M B. Davis MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>12/14/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CEMT.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. F. Hoffmann</b>				ADDRESS <b>3218 Hudson St.</b>		24a. REC'D BY REGISTRAR <b>17 105</b>	
				24b. REGISTRAR'S SIGNATURE <b>Edith</b>		DATE SIGNED <b>12/13/57</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12797

Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

Reg. Dist. No.

12779

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>L</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrison</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrison, Maryland</b>		d. STREET ADDRESS <b>Surmont</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SIDNEY</b> Middle <b>GREENBAUM</b> Last <b>GREENBAUM</b>		4. DATE OF DEATH Month <b>12</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1887</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>2</b> Min. <b>1957</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Greenbaum</b>		14. MOTHER'S MAIDEN NAME <b>Frances ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-0255</b>	
17. INFORMANT <b>Mr. Daniel S. Greenbaum-Garrison, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastases to bladder</b>			
DUE TO <b>Cancer of Rectum</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/8</b> , 19 <b>57</b> , to <b>12/2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 27, 1957</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Jonas Cohen</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Jonas H. Cohen</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/3/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Hebrew Congre. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>North &amp; Pa. Ave</b>	
24b. REGISTRAR'S SIGNATURE <b>Dorothy Mirell</b>		DATE <b>12/3/57</b>	

BREATH V. S.

DEC 4 1977

RECEIVED

## 12798 CERTIFICATE OF DEATH

12798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea Rural</u>			c. LENGTH OF STAY IN 1b <u>life</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7415 Kenlea Avenue</u>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea Rural</u> X		
			d. STREET ADDRESS <u>7415 Kenlea Avenue</u>		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Karl Konrad Hacke</u>			4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1904</u>		9. AGE (In years last birthday) <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Motors</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Hacke</u>			14. MOTHER'S MAIDEN NAME <u>Kunigunda Hopfengartner</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-01-3369</u>	17. INFORMANT <u>Mrs. Dorothy E. Hacke</u> Address <u>7415 Kenlea Avenue</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>rectum ca</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> 19 <u>57</u> to <u>Dec 13</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 12</u> 19 <u>57</u> , and that death occurred at <u>SP</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 W. OVERLEA AVE</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>ZIGLER, R.R. MD BALTO, 6 Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>London Funeral Home</u>			24a. REC'D BY REGISTRAR <u>19 1957</u>		
			24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 9 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12799

## CERTIFICATE OF DEATH

12781/4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Baltimore</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1050 Old North Point Road</u>				d. STREET ADDRESS <u>1050 Old North Point Road</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM EDWIN HACKETT</u>				4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1914</u>	9. AGE (In years last birthday) <u>43 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Electric Co. Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin M. Hackett</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Hilmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. Margaret Hackett</u> Address <u>1050 Old North Point Road</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic Glomerular Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> (c) <u>15 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>May</u> Day <u>19</u> Year <u>1957</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1010 NORTH Point Rd</u>	
20f. (City or town) <u>Baltimore</u>				20g. (County) <u>Ind</u>		20h. (State) <u>Ind</u>	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>Dec 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>57</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>				ADDRESS (Street, city or town, state) <u>1010 NORTH Point Rd</u>			
DATE SIGNED <u>12/11/57</u>				PHYSICIAN'S NAME (Type) <u>MORRIS A. Jacobs</u> <u>Baltimore</u> <u>24</u> <u>Ind</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colgate, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road,</u>				24a. REC'D BY REGISTRAR <u>DEL 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jawson H. Hiley</u>	

RECEIVED

U. S. DEPT. OF JUSTICE

RECEIVED

12782

12800

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>				d. STREET ADDRESS <b>4 Dutton Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Ennis</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>V</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 23, 1930</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>William B. Ennis</b>				14. MOTHER'S MAIDEN NAME <b>Em. S. <del>Smith</del> LETSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>--</b>				16. SOCIAL SECURITY NO <b>--</b>		17. INFORMANT Address <b>Mrs. Henry H. Helfrich 4 Dutton Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO <b>Carcinoma of Jaw</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pneumo pneumonia</b> (c) <b>Pneumo pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 mos - 3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension 4 mm</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug 1958</b> to <b>Dec 23, 1957</b> , that I last saw the deceased alive on <b>Dec 23, 1957</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1118 St. Paul St - Balto.</b> DATE SIGNED <b>Wetherbee Forl</b>							
ACTUAL SIGNATURE <b>Wetherbee Forl</b> M.D. <b>1118 St. Paul St - Balto.</b>							
PHYSICIAN'S NAME (Type) <b>Wetherbee Forl</b> <b>1118 St. Paul St -</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Com.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Forley Funeral Home Catonsville, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE DEC 30 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Wetherbee</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 1956

BUREAU V. S.



## 12801 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - MILLERS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>CHARLES LESLIE HARRIS</u>		4. DATE DEATH Month <u>DEC</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 3, 1903</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cranter-ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Harris</u>		14. MOTHER'S MAIDEN NAME <u>Florence Schaefer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Chas. L. Harris - Millers, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/5/57</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 7, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons - Towson, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 9 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Reed Smith</u>			

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

U. S. A.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12802 CERTIFICATE OF DEATH

1278438

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore, Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1515 Joppa Road</u>		d. STREET ADDRESS <u>1515 Joppa Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Alexander Taylor Harrison</u>		4. DATE OF DEATH Month Day Year <u>Dec. 16, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1903</u>
9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Hotel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mgr</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Tudor Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte F. Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-0-0</u>	
17. INFORMANT <u>D. Heyward Hamilton, Jr.</u>		Address <u>Ruxton 4, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ALCOHOLIC CIRRHOSIS OF LIVER</u> DUE TO (c) <u>WITH ASCITES AND MALNUTRITION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 WEEKS</u> <u>1 YEAR</u> <u>10 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 16, 1956</u> to <u>DEC 16, 1957</u> , that I last saw the deceased alive on <u>DEC 16, 1957</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>18 E. EAGER ST. BALTO. 2 MARYLAND</u> ACTUAL SIGNATURE <u>Ralph G. Hills</u> M.D. <u>18 E. Eager St. Baltimore 2, Md.</u> PHYSICIAN'S NAME (Type) <u>Dr. Ralph G. Hills</u> <u>Dec 17 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>DEC 18 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herry Jenkins</u>		ADDRESS <u>4905 York Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 15</u>		24b. REGISTRAR'S SIGNATURE <u>Nobel Gray</u>	

BUREAU V. S.

1957

J. C.

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12803

## CERTIFICATE OF DEATH

12785 32  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>WEST OCEAN CITY, MD.</b>		b. COUNTY <b>WIC.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WEST OCEAN CITY RT. #1</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>HASTINGS, HARRY WILLIAM</b>				4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/15/10</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>15</b>		IF UNDER 24 HRS Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FISHERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>HASTINGS, LAURENT</b>				14. MOTHER'S MAIDEN NAME <b>SARA FISHER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>WW II ARMY</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG</b>						<b>2 months</b>	
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						(b) <b></b>	
						(c) <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <b></b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/26/57</b> , to <b>12/1/57</b> , that I last saw the deceased alive on <b>11/30/57</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b></b>							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b>							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>12/3/57</b>		<b>EVERGREEN</b>		<b>Berlin Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dwight A. Bullock</b>				ADDRESS <b>Berlin Md</b>		24. DECEASED BY REGISTRAR <input type="checkbox"/> REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>	

RECEIVED

DEC 11 1931

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12719

## CERTIFICATE OF DEATH

12786 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ----		d. STREET ADDRESS <u>1901 Walnut Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Harbick</u> Last <u>Harbick</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888 Oct 14 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Caldo Slovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Don't Know</u>		14. MOTHER'S MAIDEN NAME <u>Don't Know</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Vincent Harbick 6432 O'Donnell</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-20</u> , 19 <u>57</u> , to <u>12-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-16</u> , 19 <u>57</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack C Collins</u>		ADDRESS (Street, city or town, state) <u>BAL 22 Md</u>	
PHYSICIAN'S NAME (Type) <u>JACK C COLLINS</u>		DATE SIGNED <u>Dec 24 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 24 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Stanislaus</u>		22d. LOCATION (City, town, or county) (State) <u>Dundalk Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u>		ADDRESS <u>Dundalk Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Kelly</u>	

BUREAU V. S.

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12720 CERTIFICATE OF DEATH

12787 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>18 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2903 Dunglow Road</b>		d. STREET ADDRESS <b>2903 Dunglow Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES MATTHEW HELMAN, Sr.</b>		4. DATE OF DEATH Month Day Year <b>December 5th, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 4, 1903</b>
9. AGE (In years last birthday) yrs <b>54</b>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>John Helman</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Blough</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>190-05-4498</b>	
17. INFORMANT <b>Elizabeth L. Helman</b>		Address <b>as in #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Thoracic Carcinoma</b> DUE TO <b>Carcinoma of Sigmoid Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1-2 yrs?</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 1</b> , 19 <b>57</b> , to <b>Dec. 5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 5</b> , 19 <b>57</b> , and that death occurred at <b>6:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>James T. Means M.D. 12/7/57</b>			
PHYSICIAN'S NAME (Type) <b>James T. Means, M.D., 4th &amp; D Sts, Sparrows Point 19, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Arthur Bradley</b>		ADDRESS <b>Dundalk 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. Kelly</b>	

U. S. A.

1947

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12804 CERTIFICATE OF DEATH

12788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>5yr6mth10dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>			
f. STREET ADDRESS <b>3507 Walbrook Ave.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle Last <b>Hepperla</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 5, 1871</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>secretary</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Henry Hepperla</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Coale</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>no</b>				16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS. +</b>							
400.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>GENERALIZED ARTERIOSCLEROSIS</b> " " "							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct. 18, 1957</b> , to <b>DEC. 4, 1957</b> , that I last saw the deceased alive on <b>DEC. 3, 1957</b> , and that death occurred at <b>2:43 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Jonas R. Rapoport</b> M.D.				SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) <b>Jonas R. Rapoport M.D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. J. Sicker</b>				24a. REC'D BY REGISTRAR <b>DEC 5 1957</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

THE SPIRITUAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRITISH V.S.

DEC

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12805 CERTIFICATE OF DEATH

Reg. Dist. No. 12789

45

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7009 Dunbar Road</b>				d. STREET ADDRESS <b>7009 Dunbar Road #22</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>EDWARD</b> Last <b>Hertje</b>				4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24, 1860</b>	9. AGE (In years last birthday) <b>97</b> yrs	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>19</b> Min <b>57</b>	IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>19</b> Min <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pomeroy, Ohio</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Valentine Hertje</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Huff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ida Clark-7009 Dunbar Road-Balto. 22, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio Sclerosis</b> DUE TO (c) <b>20 years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Feb Jan</b> , 19 <b>55</b> , to <b>12-1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12-1</b> , 19 <b>57</b> , and that death occurred at <b>10:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 Kinslip</b> DATE SIGNED <b>12-1-57</b>							
ACTUAL SIGNATURE <b>Jack C Collins</b>				M.D. <b>BAL 22</b>			
PHYSICIAN'S NAME (Type) <b>JACK C COLLINS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/4/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hertje Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jackson County, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker &amp; Sons</b>				ADDRESS <b>Wm. J. Tucker &amp; Sons</b>		24a. REC'D BY REGISTRAR DATE <b>12/3/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>			

BUREAU V. S.

REC 4 1957

RECEIVED

## 12806 CERTIFICATE OF DEATH

12790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>2017 E. 32nd St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Osburn Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace R. Hildreth</u>		4. DATE OF DEATH Month Day Year <u>12/25/57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/17/1922</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LIQUOR BOARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OFFICE</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Hildreth</u>		14. MOTHER'S MAIDEN NAME <u>M. Cornelia Hildreth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Clarence Hildreth</u>		Address <u>2017 E. 32nd. St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Phenothiazine Heart Disease</u> DUE TO <u>Hypertension, Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Gradual</u> <u>"</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1940</u> , to <u>Dec 26, 1957</u> , that I last saw the deceased alive on <u>Dec 24, 1957</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Hoody</u>		M.D. <u>1403 Park Ave</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Hoody</u>		ADDRESS (Street, city or town, state) <u>Baltimore 17 md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE 12 2 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hoody</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 6 1961

RECEIVED



1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Rd.</u>				d. STREET ADDRESS <u>Ridge Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Daniel W. Hilker</u> First Middle Last				4. DATE OF DEATH <u>Dec. 20, 1957</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1864</u>	9. AGE (In years and birthday) <u>93</u> yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Hilker</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Zimmerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Cora Hilker, Freeland Md.</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>marked obesity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 hours.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Cerebral thrombus — no injury</u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-4-</u> 19 <u>55</u> to <u>12-19-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12-19-57</u> , 19 <u>57</u> , and that death occurred on <u>10.30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Robinson</u> M.D.				ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u> DATE SIGNED <u>12-23-57</u>			
PHYSICIAN'S NAME (Type) <u>R. ROBINSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE/THEREOF <u>12/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Steltz Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Rock, Pa. R.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Horstenstein</u> ADDRESS <u>New Freedom, Pa.</u>				24. REG'D BY REGISTRAR <u>12-23-57</u> REGISTRAR'S SIGNATURE <u>Chester L. Sultany</u> DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12792

12808

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1807 E. Joppa Road</u>		d. STREET ADDRESS <u>1807 E. Joppa Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. John M. Hilliard</u> First Middle Last		4. DATE OF DEATH <u>December 17</u> h <u>19</u> 57	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1898</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John M. Hilliard</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-7292</u>	
17. INFORMANT <u>Mrs. Anna Marie Hilliard,</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO <u>Epidermoid Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probably lung</u> (c) <u>probable lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>March 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>December 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 11</u> , 19 <u>57</u> , and that death occurred at <u>9 P. M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>William L. Garlick</u> M.D.		ADDRESS (Street, city or town, state) <u>700 N. Charles St</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>William L. Garlick, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/14/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>DEC 17 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

12809 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9yr8mth16dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows, Point, Md.</b>		d. STREET ADDRESS <b>432 "F" Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sebastian</b> Middle <b>Hock</b> Last <b>Hock</b>		4. DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>19 57</b>	
5 SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 1, 1882</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months <b>75</b> Days <b>17</b> Hours <b>19</b> Min <b>57</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13 FATHER'S NAME <b>Adam Hock</b>	
14 MOTHER'S MAIDEN NAME <b>Maggie Schindhelm</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>no</b>	
16 SOCIAL SECURITY NO. <b>Unknown</b>		17 INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized peritonitis</b> <b>605X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ruptured bladder</b> DUE TO (c) <b>Acute urinary retention and cystitis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 20, 1957</b> , to <b>Dec. 17, 1957</b> , that I last saw the deceased alive on <b>Dec. 17, 1957</b> , and that death occurred at <b>12 P. M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 12-18-57</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL 12-18-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12-21-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Gailer</b>		ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 23 1957</b>		24b. REG. STRAR'S SIGNATURE <b>Overhiser</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1957

WED

12810 CERTIFICATE OF DEATH

1279431  
Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Holbrook</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Holbrook</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Mariettaville P.O. Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>va</u> Last <u>Horn</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1957</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1868</u>	9. AGE (In years last birthday) <u>89</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jesse Dell</u>				14. MOTHER'S MAIDEN NAME <u>Chusanna Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Parker, Mariettaville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Cardiac failure,</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerosis, hypertension, left heart failure</u> DUE TO (c) <u>Carcinoma of breast i metastasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1956</u> <u>+0</u> <u>Dec 1957</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> 19 <u>57</u> , to <u>Dec 11, 1957</u> , that I last saw the deceased alive on <u>10 Dec</u> 19 <u>57</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Schwarzk, Md.</u>		DATE SIGNED <u>11 Dec 57</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				<u>BY KEESVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>12-14-57</u>	<u>Ward's Chapel</u>		<u>Holbrook Balt Co, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u>				ADDRESS <u>Keesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12-13-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Jm. Martins</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FRANKLIN D. ROOSEVELT

DEC 1 1941

RECEIVED  
U.S. DEPT. OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12811 CERTIFICATE OF DEATH

Reg. Dist. No.

12795 3 3

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>1903 E. NORTH AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>KINDLE</b> Middle <b>HOWE</b> Last				4. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>10.10.03</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN HOWE</b>				14. MOTHER'S MAIDEN NAME <b>EMMA MC BRIDE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>tuberculous meningitis</b> <b>ooax</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>pulmonary tuberculosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0231</b> <b>LATE LATENT SYPHILIS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 26, 1956</b> to <b>December 19, 1957</b> , that I last saw the deceased alive on <b>12-19-57</b> , and that death occurred at <b>10:45 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b>							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Dec. 24, 1957</b>		<b>St. Peters</b>		<b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc. 1217 St. Paul St.</b>				24a. REC'D BY REGISTRAR <b>DEC 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Gies</b>	

BUREAU V. J.

DEC 14 1951

RECEIVED  
FBI  
DEC 14 1951

12812

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FEDERALSBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>ROUTE #1</b>	
3. NAME OF DECEASED (Type or print) First <b>LeROY</b> Middle <b>J</b> Last <b>HULLIGER, SR.</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>22</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-16</b>
9. AGE (In years lost birthday) <b>41</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>PRESTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN I. HULLIGER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA KNOX</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW-11</b>		16. SOCIAL SECURITY NO. <b>578-01-5210</b>	
17. INFORMANT <b>VET. ADM. HOSP., CLIN. RECORDS, FT HOWARD MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RHEUMATIC CARDIOVASCULAR DISEASE, AORTIC STENOSIS</b> <b>MYOXY AND INSUFFICIENCY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 11, 19 57</b> to <b>December 22, 19 57</b> and that death occurred at <b>12:35 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>12/23/57</b>			
ACTUAL SIGNATURE <b>Irving Freeman</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 26, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>HILL CREST CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FEDERALSBURG, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton &amp; Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 26 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Jawson L. Farley</b>	

J.J. FRAMPTON &amp; SON, 216 N MAIN ST FEDERALSBURG MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 14 1954

BUNNELL

## 12725 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>L</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3900 Annapolis Road</u>				d. STREET ADDRESS <u>3900 Annapolis Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>M.</u> Last <u>Hyson</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 25, 1878</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Franklin W. Aschemeier, Jr., 3900 Annapolis Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>4450</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive C.V.D.</u> DUE TO (c) <u>56 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month <u>Dec</u> Day <u>5</u> Year <u>1957</u> Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>57</u> , to <u>Dec 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>57</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2361 Annapolis Rd.</u> DATE SIGNED <u>Paul Sehnfeld</u> ACTUAL SIGNATURE <u>Paul Sehnfeld</u> M.D. PHYSICIAN'S NAME (Type) <u>Paul Sehnfeld</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Ed M. Luffey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

.12813

## CERTIFICATE OF DEATH

12798 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bauernschmidt Manor		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bauernschmidt Manor-Balto.20, Md.	
		d. STREET ADDRESS Route 1, Box 727.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last VACLAV JOSEPH JANATA		4. DATE OF DEATH December 4 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 16, 1879
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. Hardware		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Anton Janata		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address		Amelia Kotras, dght, above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Antero-sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobar Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1955, to Dec 4, 1957, that I last saw the deceased alive on Dec 4, 1957, and that death occurred at 5:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli M.D.		ADDRESS (Street, city or town, state) 108 S. TAYLOR AVE	
PHYSICIAN'S NAME (Type) JOSEPH MICELI, M.D.		DATE SIGNED 12/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/57	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		24a. REC'D BY REGISTRAR 1159	
ADDRESS 3331 Brehms Lane		24b. REGISTRAR'S SIGNATURE Edith Hurley	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

12814

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OVERLEA</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7305 LINDEN AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARA V. GRIFFIN JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>12 16 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 7. 1888</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. GRIFFIN</u>				14. MOTHER'S MAIDEN NAME <u>HARRIETT HAMILTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ELIZABETH BARTZ-2009 N. ELTON AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Hypertensive cerebral disease</u> DUE TO (c) <u>dissection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>11-24-53</u> 19 <u>53</u> to <u>12-16-57</u> 19 <u>57</u> that I last saw the deceased alive on <u>12-15</u> 19 <u>57</u> and that death occurred at <u>4:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 W. Overlea Ave. Balto. Md.</u> DATE SIGNED <u>12-16-57</u>							
ACTUAL SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>12-16-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Richard R. Rigler</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>		22d. LOCATION (City, town, or county) (State) <u>Larley, Balto. Co. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Schatzman</u> ADDRESS <u>1701 M. &amp; C. St. Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>DEC 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11 1911

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12800  
 : 12815 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. LENGTH OF STAY IN 1b <b>35 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PARADISE NURSING HOME</b>				e. STREET ADDRESS <b>MOHRS LANE &amp; PLASKI HWY</b>			
NAME OF DECEASED (Type or print) <b>MARY ELIZABETH JONES</b>				4. DATE OF DEATH <b>12/7/57</b> 19			
5. SEX <b>FEW</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 APRIL 1888</b> 69 yrs	
9. AGE (In years last birthday)		10. UNDER 1 YEAR		11. UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>CARR JACKSON</b>				14. MOTHER'S MAIDEN NAME <b>MARY D. BRINKLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>JAMES H. JONES</b>				Address <b>SAME</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegic Right.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11/2/57</b> , 19 <b>57</b> , to <b>12/7/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/6/57</b> , 19 <b>57</b> , and that death occurred at <b>1045 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. McGrath</b> M.D.				ADDRESS (Street, city or town, state) <b>1303 Frederick Rd</b> DATE SIGNED <b>12/7/57</b>			
PHYSICIAN'S NAME (Type) <b>W. E. McGrath</b>				<b>Catonsville 29md</b>			
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>12/10/57</b>		<b>JONES FAMILY PLOT 7</b>		<b>RURAL (SUNBURY, N. C.)</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. McGrath</b> ADDRESS <b>1303 Frederick Rd, Catonsville, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 9 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. McGrath</b>	

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12726 CERTIFICATE OF DEATH

128047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto Highlands</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2701 Yarnall Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>OLYMPIA-ELIZABETH KEIL</b>		4. DATE OF DEATH <b>Dec 11 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr 8, 1874</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Pierce</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Charles E. Keil</b>		Address <b>Mulberry Rd. Harwood, P.D. MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Failure</b> 4 <b>1</b> DUE TO <b>Generalized Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>None</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/19</b> 19 <b>57</b> , to <b>12/11</b> 19 <b>57</b> , that I last saw the deceased alive on <b>12/11</b> 19 <b>57</b> , and that death occurred at <b>2:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph G. Laukaitis</b> M.D.		ADDRESS (Street, city or town, state) <b>679 Washington Blvd</b> DATE SIGNED <b>Baltimore MD</b>	
PHYSICIAN'S NAME (Type) <b>Joseph G. Laukaitis, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 14 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>	22d. LOCATION (City, town, or county) (State) <b>Balto MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Orfel</b> ADDRESS <b>5311 Edmondson Ave</b>		24. REGISTRAR'S SIGNATURE <b>Geo M. Kieffer</b> DATE <b>DEC 16 1957</b>	

RECEIVED

DEC 11 1957

BUREAU V. S.

12816 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12816 CERTIFICATE OF DEATH

12802

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>41 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
f. STREET ADDRESS <b>4613 Bellview Avenue</b>				4. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>CARROLL</b> Middle <b>A.</b> Last <b>KETTLE</b>				4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>1957</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/13/10</b>	
9. AGE (In years last birthday) <b>47</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>Carroll Kettle</b>			
14 MOTHER'S MAIDEN NAME <b>Nora Peach</b>				15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWII</b>			
16 SOCIAL SECURITY NO <b>215-10-8520</b>				17. INFORMANT <b>Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS PRIMARY SITE LUNG, LEFT</b> <b>1622</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that VA attended the deceased from <b>November 9, 1957</b> to <b>December 20, 1957</b> and that death occurred at <b>12:30 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b> DATE SIGNED <b>12/20/57</b>							
PHYSICIAN'S NAME (Type) <b>C.J. PAPAISTRAT, M.D.</b>				M.D. <b>VAH Fort Howard, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec 23 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	
22d. LOCATION (City, town, or roadlawn) (State) <b>5608 Dogwood Rd., Baltimore, Md.</b>				22e. REC'D BY REGISTRAR <b>Willis E. Lamoreau</b>			
23. GENERAL DIRECTOR'S SIGNATURE <b>Willis E. Lamoreau</b>				24b. REGISTRAR'S SIGNATURE <b>E. J. Farber</b>		24c. DATE <b>12/20/57</b>	

Willis E. Lamoreau 4510 Liberty Heights Ave. Balto., Md.

E J

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURMAN V. S.

DEC 23 1957

RECEIVED V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Medical examiner notified and released body. 12727 **CERTIFICATE OF DEATH**

1280342

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) b. STATE <b>MD</b> <b>404 N. Rolling Road,</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 28, Md.</b>		d. STREET ADDRESS <b>1404 N. ROLLING RD.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Relay Hill Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Horace McClelland King</b>		4. DATE OF DEATH Month Day Year <b>12 26 19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>DIVORCED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>Sept. 7-1920</b>
9. AGE (In years last birthday) <b>37</b> yrs		IF UNDER 1 YEAR Months Days <b>3 18</b>	IF UNDER 24 HRS. Hours Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none at present</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Park Avenue, New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>Citizen U.S.A.</b>	
13. FATHER'S NAME <b>C. Leroy King</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>U.S. Army</b>		16. SOCIAL SECURITY NO. <b>414-26-4143</b>	
17. INFORMANT <b>Mother: Mrs. John S. Albert</b>		Address <b>Ridgeway</b> Phone <b>7-7416</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Alcoholism with delirium</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Possible Barbiturate intoxication</b> DUE TO (c) <b>Chronic Alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>  <b>17 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 23</b> , 19 <b>57</b> , to <b>Dec. 26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 26</b> , 19 <b>57</b> , and that death occurred at <b>5:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Lewis P. Gundry</b> M.D.		PHYSICIAN'S NAME (Type) <b>Lewis P. Gundry, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC. 28/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MEADOW RIDGE</b>		22d. LOCATION (City, town, or county) (State) <b>DORSEY MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILKE FUNERAL DIR.</b>		ADDRESS <b>4101 EDMONDSON AVE</b>	
24a. REC'D BY REGISTRAR <b>Dr. G. M. H. H. H.</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. G. M. H. H. H.</b>	

BUREAU V. E.

1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12804**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3yr11mth12days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Larchmont, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>2505 Poplar Drive</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Florence</b> Middle <b>A.</b> Last <b>Knight</b>				<b>4. DATE OF DEATH</b> Month <b>Dec.</b> Day <b>5</b> Year <b>19 57</b>			
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>12/9/18-</b>		<b>9. AGE</b> (In years, last birthday) <b>84?</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>84?</b> Days <b>84?</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>			
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO <b>Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>fracture right hip</b> DUE TO <b>Accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rogers Indurum Splint. use + Cast Symptomatic</b>							
<b>20a. EXTERNAL CAUSE WAS PR. MARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. fell from bench on 11-12-57 sustaining an intertrochanteric frac. of rt. hip</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>11-12 19 57</b> Hour <b>1:30</b> P. M.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>			
<b>20f. (City or town)</b> <b>Catonsville</b>		<b>20g. (County)</b> <b>28, Md.</b>		<b>20h. (State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>George M. Kieffer</i> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>12-5-57</b> <b>EXAMINER'S NAME (Type)</b> <b>George M. Kieffer, M. D.</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MED. CAL EXAMINER</b> <input type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12/9/1957</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cem.</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>Baltimore, Maryland</b>		<b>22e. (State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Edward J. Brunsell Per E. Adair</i>			<b>24a. REC'D BY REGISTRAR</b> <b>DEC 9 '57</b>				
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Per. Brunsell</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

U.S. AIR FORCE

12818

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.1 PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)

Towson

c. LENGTH OF STAY IN 1b

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission on)

a. STATE Maryland

b. COUNTY Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)

Baltimore

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

1205 Merediths Ford Road

d. STREET ADDRESS

2227 Kentucky Avenue

e. IS RESIDENT ON A FARM  
YES ☐ NO ☒3. NAME OF DECEASED  
(Type or print)

Mr. Le Roy

J.

Koeneke

4. DATE OF DEATH

December 25th 1957

5. SEX

male

6. COLOR OR RACE white

7. MARRIED ☒NEVER MARRIED ☐

8. DATE OF BIRTH

Nov. 6, 1911

9. AGE (In years last birthday)

46 yrs

IF UNDER 1 YEAR, IF UNDER 24 HRS.

Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk, Continental Can Co

10b. KIND OF BUSINESS OR INDUSTRY

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Koeneke

14. MOTHER'S MARRIED NAME

Catherine Dressler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT

Address

Mrs. Virginia Koeneke, 2227 Kentucky Av

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)4. DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b)  
(c)

Coronary Thrombosis Sudden

INTER-RELATIONSHIP BETWEEN CAUSE AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m. p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles F. O'Donnell

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

12/26/57

EXAMINER'S NAME (Type)

Charles F. O'Donnell

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/30/57

22c. NAME OF CEMETERY OR CREMATORY

Baltimore National

22d. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Leonard J. Ruck 5305 Harford Road.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Nebel Gray

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12819  
CERTIFICATE OF DEATH

12896  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3503 Midfield Road</u>		d. STREET ADDRESS <u>3503 Midfield Road</u>	
3. NAME OF DECEASED (Type or print) <u>Irving M. Kolker</u>		4. DATE OF DEATH <u>12-14-1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>60 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Monish</u>		14. MOTHER'S MAIDEN NAME <u>Faga</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>War I</u>		16. SOCIAL SECURITY NO. <u>Rosa Kolker</u>	
17. INFORMANT <u>Rosa Kolker</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>few seconds</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1944</u> to <u>Dec 14</u> , 1957, that I last saw the deceased alive on <u>Dec 11</u> , 1957, and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Trescher</u> M.D.		ADDRESS (Street, city or town, state) <u>1035 N. Calvert St. Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>John H. Trescher</u>		DATE SIGNED <u>Dec. 15, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		24a. REC'D BY REGISTRAR <u>DEC 18 1957</u>	
ADDRESS <u>2100 Entwistle Place</u>		24b. REGISTRAR'S SIGNATURE <u>Jessie M. Wells</u>	

BURTONS V. E.

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1967-1968



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The form copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12721 CERTIFICATE OF DEATH

12807

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7016 Dunhill Rd.</u>				STREET ADDRESS (If rural give location) <u>7016 Dunhill Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>FRANK KOPECNI</u>				4. DATE OF DEATH <u>Dec. 12, 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>October 10, 1883</u>	
9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>brick layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>John Kopecni</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Anthony P. Kopecni 7016 Dunhill Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4. IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Cardio Vase Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Brucella + Pulm. Emphysema</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1957</u> to <u>Dec. 12, 1957</u> , that I last saw the deceased alive on <u>Dec. 11, 1957</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. D. Groomer</u>				DATE SIGNED <u>12/13/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Dec. 14, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REG'D BY REGISTRAR <u>1957</u>		REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Homes, Balto., Md.</u>			

U.S. AIR FORCE

100-100000

RECEIVED

12820

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>1807 Linden Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Adelaide</b>		First <b>Adelaide</b> Middle <b>Kratz</b> Last <b>Kratz</b>		4. DATE OF DEATH Month <b>12</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-24-1875</b>		9. AGE (In years, 1 day, 1 yr.) <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George E. Nicholson</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Musgrove</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Alton Kratz (S on)</b> Address <b>332 Lambeth Road Catonsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterioscler. Cardiac. Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/7</b> 19 <b>57</b> , to <b>12/7</b> 19 <b>57</b> , that I last saw the deceased alive on <b>12/7</b> 19 <b>57</b> , and that death occurred at <b>3:40 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachslar</b> M.D. <b>Spring Grove State Hosp.</b> <b>12/7/57</b> PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b> <b>Catonsville, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave/</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 10 57</b>		24b. REGISTRAR'S SIGNATURE <b>Richard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

12821

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>116 Forest Avenue</b>				d. STREET ADDRESS <b>116 Forest Avenue #28</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>LAVINIA</b> Last <b>KRIEB</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED XXX</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1870</b>	9. AGE (In years last birthday) <b>87</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William F. Cain</b>				14. MOTHER'S MAIDEN NAME <b>Lavinia E. Glass</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Theodore Clark-116 Forest Avenue #28</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial insufficiency</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertensive, cardio-vascular disease</b> DUE TO (c) <b>arteriosclerotic</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b> <b>13 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Apr 20, 1944</b> , to <b>Dec 7, 1957</b> , that I last saw the deceased alive on <b>Dec 7, 1957</b> , and that death occurred at <b>10:12</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>416 Edmondson Ave Baltimore, 29, Md.</b> DATE SIGNED <b>Dec 8/1957</b>							
ACTUAL SIGNATURE <b>George A Knipp</b>		M.D. <b>416 Edmondson Ave</b>					
PHYSICIAN'S NAME (Type) <b>George A Knipp M.D.</b>		<b>Baltimore, 29, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/10/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiebner &amp; Son</b>		ADDRESS <b>Worship &amp; Pa Ave</b>		24a. REC'D BY REGISTRAR DATE <b>57</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. J. Tiebner</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANLEY A. S.

DEC 19

STANLEY A. S.

12822 CERTIFICATE OF DEATH

12810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>				d. STREET ADDRESS <b>3501 Calloway Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>ELLEN</b> Middle <b>BARBARA</b> Last <b>KUNKEL</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>4,</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1890</b>	9. AGE (In years last birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Grissinger</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jane Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Mr. Irvin T. Kunkel - 2113 Southland Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Cerebral Vascular Disease</b> (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11:10</b> to <b>12:14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/4</b> , 19 <b>57</b> , and that death occurred at <b>12:14</b> P.M. from the causes and on the date stated above.							DATE SIGNED <b>12/6/57</b>
ACTUAL SIGNATURE <b>Joseph G. Laukaitis</b>				ADDRESS (Street, city or town, state) <b>679 Washington Blvd.</b>		DATE SIGNED <b>12/6/57</b>	
PHYSICIAN'S NAME (Type) <b>Joseph G. Laukaitis, M.D.</b>				<b>679 Washington Blvd. Balto. 30, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>12/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Emanuel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Lewisberry, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker &amp; Sons Balto. 17</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 9 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Tucker</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1954

100-100000



12823 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6001 Gwynn Oak Ave.</b>		d. STREET ADDRESS <b>6001 Gwynn Oak Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Lange</b> Last <b>Lange</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1877</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>Henry Lange</b>		14 MOTHER'S MAIDEN NAME <b>Florence Speleshouse</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Florence Lange - 6001 Gwynn Oak Ave.</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>- Generalized Arterio - Sclerosis -</b> (c) <b>- Cerebral Thrombosis -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b> <b>5 yrs.</b> <b>1 wk. -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis of Spine</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 7 - 1954</b> , to <b>Dec. 23, 1957</b> , that I last saw the deceased alive on <b>Dec. 22, 1957</b> , and that death occurred at <b>12:17 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Chambers</b> M.D.		ADDRESS (Street, city or town, state) <b>4108 Liberty Hts Ave - Balto - Md.</b> DATE SIGNED <b>12-23-57</b>	
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		<b>4108 Liberty Hts Ave - Balto - Md. - 12-23-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Cremation</b>	<b>12/24/57</b>	<b>Loudon Park Crem.</b>	<b>Balto., Md.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Chas. J. Tiekner &amp; Sons - Balto</b>		24a. REC'D BY REGISTRAR <b>Dr. Hm. Mantony</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

DEC 22 1911

RECEIVED

12824

## CERTIFICATE OF DEATH

12812

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN TB <b>20 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. STREET ADDRESS <b>4201 RIDGEWOOD AVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AMELIA</b> Middle <b>MARY</b> Last <b>LANTZ</b>				4. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>FE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-9-1867</b>	
9. AGE (In years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>FREDERICK WIENEKE</b>				14. MOTHER'S MAIDEN NAME <b>KATHERINE WAGONER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic Cardio</b> <b>4201</b> DUE TO <b>Vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-19</b> , 1954, to <b>12-18</b> , 1957, that I last saw the deceased alive on <b>12-18</b> , 1957, and that death occurred at <b>12:40 P.M.</b> , from the causes and on the date stated above <b>Walter T. Keas</b> ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED							
ACTION SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 23 1957

100-100000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12813

12825

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

23

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 22, Md.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dolfield Road</b>			d. STREET ADDRESS <b>1911 Mills Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Stephen</b> Middle <b>Paul</b> Last <b>Lepus Jr.</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1934</b>	9. AGE (In years last birthday) <b>23</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Stephen Lepus Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Helen Loneala</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.2</b>		17. INFORMANT <b>Robert Lepus, 34 Riverside Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b> 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVA. BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hooked hose onto automobile exhaust &amp; ran same in car window.</b>			
20c. TIME OF INJURY Hour a. m. p. m. <b>Dec. 10 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods-Dolfield Rd., Owings Mills, Balto., Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>12-14-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 17, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maczorowski Funeral Home</b>			24a. REC'D BY REGISTRAR DATE <b>12-14-57</b>		
ADDRESS <b>2525 Fleet St Baltimore, Md.</b>			24b. REGISTRAR'S SIGNATURE <b>Mary B. Elvine</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12826

## CERTIFICATE OF DEATH

Reg. Dist. No.

12814

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Extensville</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>			d. STREET ADDRESS <u>3606 Clarity Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Solomon</u> Middle <u>LEVINSON</u> Last <u>LEVINSON</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/1</u>	9. AGE (in years last birthday) yrs <u>61</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>2</u> Days <u>4</u> Hours <u>1</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Practice</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Max Levinson</u>		
14. MOTHER'S MAIDEN NAME <u>Bella J. Smith</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>PT.'s record</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>PT.'s record</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular</u> DUE TO <u>coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis, generalized</u> DUE TO <u>curable</u> (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u>	(County) <u>—</u>	(State) <u>—</u>
21. I certify that I attended the deceased from <u>12-22-57</u> to <u>12-24-57</u> , that I last saw the deceased alive on <u>12-22-57</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Sivela Wachslar M.D.</u>		ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp. Catonsville 20 Md.</u>			
PHYSICIAN'S NAME (Type) <u>DR. S. WACHSLAR</u>		DATE SIGNED <u>12/25/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Belmont &amp; Sons, Inc.</u>		ADDRESS <u>1124-26 W. North Ave.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 57</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

MEDICAL CERTIFICATION

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## Reg. Dist. No.

## MEDICAL CERTIFICATION

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ROBERTO V. S.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12817

Reg. Dist. No.

12829

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bank of Back River.</b>		e. STREET ADDRESS <b>318 Oriole Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS JEFFERSON LYNN</b>		4. DATE OF DEATH <b>December 17 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 29, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		12. KIND OF BUSINESS OR INDUSTRY <b>WEAVER.</b>	
13. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PA.</b>		14. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. FATHER'S NAME <b>WILLIAM LYNN</b>		16. MOTHER'S MAIDEN NAME <b>MATILDA ?</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		18. SOCIAL SECURITY NO <b>160-09-0214</b>	
19. INFORMANT <b>CATHERINE M. LYNN</b>		Address <b>SAME.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning, Found Drowned.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1.0</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Found drowned.</b>	
20c. TIME OF INJURY Month, Day, Year <b>12/17 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Back River</b>		20f. (City or town) <b>Baltimore</b> (County) <b>Md.</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/18/57</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-21-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM.</b>		22d. LOCATION (City, town, or county) <b>4300 OLD FREDERICK RD. BALTO., MD.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Giler</b>		ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>	
24a. RECEIVED BY REGISTRAR <b>Edith Hurley</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>	

W. A. R.

DEC 20

1951

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12828 CERTIFICATE OF DEATH

128138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>500 Fairway Court</b>				d. STREET ADDRESS <b>3214 Kanyon Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>LYNCH</b> Last				4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 18, 1883</b>	
9. AGE (In years last birthday) <b>74</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>George Bauer</b>			
14. MOTHER'S MAIDEN NAME <b>Lena Frederick</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT <b>John C. Lynch, husband, above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1. X</b> DUE TO <b>Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized metastasis, abdominal</b> (c) <b>Carcinoma of Ovary</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized metastatic carcinoma</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>June 1, 1957</b> to <b>Dec 11, 1957</b> , that I last saw the deceased alive on <b>Dec 8, 1957</b> , and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles E. Carr, Jr.</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>1201 Y. M. Road, Baltimore, Md. 12, Mar 1, 1957</b>			
PHYSICIAN'S NAME (Type) <b>Chas. E. Carr, Jr., M.D.</b>				Baltimore 12, Mar 1, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/14/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>				ADDRESS <b>Funeral Home 3331 Prema Lane</b>			
24a. REC'D BY REGISTRAR <b>DATE 12/15/57</b>				24b. REGISTRAR'S SIGNATURE <b>Robert Gray</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4-1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 17 1957

BUREAU V. S.

12831

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>19yr8mth16dys</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>UNKNOWN</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Rosie</b>		Middle <b>Mach</b>		Last <b>Mach</b>		4. DATE OF DEATH Month <b>December</b>		Day <b>1</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>unknown</b>		9. AGE (In years last birthday) <b>60?</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>UNKNOWN Martin Mach</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN Mary Giza</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		21. I certify that I attended the deceased from <b>Nov. 30 1957</b> , to <b>Dec. 1 1957</b> , that I last saw the deceased alive on <b>Dec. 1 1957</b> , and that death occurred at <b>1:00p M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>12-2-57</b>	
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>Stella Wachslar, M. D.</b>		Catonsville 28, Maryland		22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 4, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>1300 Dundalk Ave + Balto, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Weber 705 S Ann st</b>		24a. REC'D BY REGISTRAR <b>DEC 4 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Redman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12831

## CERTIFICATE OF DEATH

## 12819

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Aero Acres Rural d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 48 Rt. Wing Drive				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <span style="float: right;">b. COUNTY</span> Maryland <span style="float: right;">Baltimore</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aero Acres Rural d. STREET ADDRESS 48 Rt. Wing Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Arthur H. Maddox		<b>4. DATE OF DEATH</b> Month Day Year 12/14/57		<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> white		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 1/29/1881		<b>9. AGE</b> (In years last birthday) 76 yrs		<b>IF UNDER 1 YEAR</b> Months Days Hours Min		<b>IF UNDER 24 HRS</b> Hours Min	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Land Owner				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Real Estate				<b>11. BIRTHPLACE</b> (State or foreign country) Virginia				<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.					
<b>13. FATHER'S NAME</b> Bushrod Maddox						<b>14. MOTHER'S MAIDEN NAME</b> Lucy Weekley											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) no				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address Mrs. Bessie L. Maddox 48 Rt. Wing Drive									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio-vascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)														<b>INTERVAL BETWEEN ONSET AND DEATH</b> 4 yrs.			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19						<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from Dec 10, 1957, to Dec 14, 1957, that I last saw the deceased alive on Dec 14, 1957, and that death occurred at 8:00 P.M. from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>James H. [Signature]</u> M.D. <u>422 E. [Signature]</u> 12/16/57 PHYSICIAN'S NAME (Type)																	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial				<b>22b. DATE THEREOF</b> 12/17/57		<b>22c. NAME OF CEMETERY OR CREMATORY</b> St. Michaels Lutheran				<b>22d. LOCATION</b> (City, town, or county) (State) Perry Hall Maryland							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>						<b>ADDRESS</b> <u>7401 Belair Rd.</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>12/19/57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ERNEST V. S.

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12832

CERTIFICATE OF DEATH

12821

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea Rural</u>			
c. LENGTH OF STAY in 1b <u>Life</u>				d. STREET ADDRESS <u>1201 Fullerton Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1201 Fullerton Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Augusta</u> Middle <u>Mallon</u> Last <u>Mallon</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Seamstress</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Misikofski</u>				14. MOTHER'S MAIDEN NAME <u>Anna Bunk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>220-30-3604</u>		17. INFORMANT <u>Miss Martha Mallon</u> Address <u>4201 Fullerton Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William F. Fritz</u>		M.D. <u>2 W. University Pharmacy</u>		ADDRESS (Street, city or town, state) <u>Balto - 18 Md</u>		DATE SIGNED <u>12/15/57</u>	
PHYSICIAN'S NAME (Type) <u>William Fritz</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Luth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Howard County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Funeral Home 2401 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u>DEC 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. W. L. Kefauver</u>	

U.S. AIR FORCE

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U.S. AIR FORCE

## 12833 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1000 S. Caton Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>E.</b> Last <b>Manning</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown 1876</b>
9. AGE (In years last birthday) <b>81 1/2 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse-RET.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Bartholomew MANNING</b>		14. MOTHER'S MAIDEN NAME <b>Ann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 21</b> , 19 <b>57</b> , to <b>Dec. 7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 7</b> , 19 <b>57</b> , and that death occurred at <b>11:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslers</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 12-9-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslers, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>12-11-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel Samuel Home - Catonsville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 12 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. L. Lewis</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1917

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## 12834 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8112 Rider Ave.</b>				d. STREET ADDRESS <b>8112 Rider Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Lila</b> Middle <b>R.</b> Last <b>March</b>				4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 3, 1867</b>	
9. AGE (In years last birthday) <b>90</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Music</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William G. March</b>				14. MOTHER'S MAIDEN NAME <b>Jeanette Boyd MacLaughlin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Claire McDonnell Worthington, 8112 Rider Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 MOS.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Sept 1957</b> to <b>Dec 27, 1957</b> , that I last saw the deceased alive on <b>Dec 21, 1957</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>TIMONIA, MD.</b> DATE SIGNED <b>12/27/57</b>							
ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.				PHYSICIAN'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/30/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc 1050 N. York Rd, Towson</b>				24a. REC'D BY REGISTRAR <b>12/30/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT V. B.

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12835 CERTIFICATE OF DEATH

12824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Atlanta</b>	
c. LENGTH OF STAY IN 1b <b>10 mos. 16 da.</b>		d. STREET ADDRESS <b>875 W. Paces Ferry Road, N. W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sheppard &amp; Enoch Pratt Hosp. Towson 4, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rembert</b> Middle Last <b>Marshall</b>		4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1892</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Ella Holton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1177x</b> DUE TO (b) <b>Generalized carcinomatosis</b> DUE TO (c) <b>Carcinoma of prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 mo.</b> <b>4 mo.</b> <b>18 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 12, 1957</b> to <b>Dec. 28, 1957</b> that I last saw the deceased alive on <b>December 28, 1957</b> and that death occurred at <b>10:25 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry M. Murdock, M.D.</b> M.D.		ADDRESS (Street, city or town, state) <b>12/28/57</b>	
PHYSICIAN'S NAME (Type) <b>Harry M. Murdock, M.D.</b>		<b>Sheppard &amp; Enoch Pratt Hosp. Towson 4, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 31, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West View</b>	22d. LOCATION (City, town, or county) (State) <b>Atlanta, Ga.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		24a. REC'D BY REGISTRAR <b>JAN 2 1958</b> 24b. REGISTRAR'S SIGNATURE <b>Walter Gray</b>	

BUREAU V. S.

JAN 2 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12836

## CERTIFICATE OF DEATH

12825

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>8601 - 49th Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>F.</b> Last <b>Martin</b>				4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 26/1863</b>	9. AGE (in years last birthday) <b>94?</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At hoem</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWNX Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas G. Horton</b> <b>UNKNOWNX</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWNX Lucy Prentiss</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or none) (If yes, give war or dates of service) <b>None</b> <b>unknown</b>		16. SOCIAL SECURITY NO. <b>None</b> <b>UNKNOWN</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4. a. v. l.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov. 29</b> , 19 <b>57</b> , to <b>Dec. 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 2</b> , 19 <b>57</b> , and that death occurred at <b>7:15 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>12-2-57</b>							
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b> <b>12-2-57</b>					
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/6/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat'l Cem.</b>		22d. LOCATION (City, town or county) (State) <b>Suitland, Pr. Geo. Co. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>		ADDRESS <b>Riverside 2nd</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 9 '57</b>	24b. REGISTRAR'S SIGNATURE <b>Redeuch</b>		

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12837

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Halethorpe (Westland Gardens)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4804 Eldon Green Westland Gardens 27</u>				d. STREET ADDRESS <u>4804 Eldon Green</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Alvin</u> Last <u>Mason</u>				4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1889</u>	
9. AGE (In years last birthday) yrs. <u>68</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (ret'd)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Vernon, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George B. Mason</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.1</u>				16. SOCIAL SECURITY NO <u>217-01-0122</u>		17. INFORMANT <u>Bertina M. Mason, 4805 Eldon Garden</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>150X</u> <u>ESOPHAGUS &amp; METASTASIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ESOPHAGUS &amp; METASTASIS</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>7/1</u> 19 <u>57</u> to <u>12/7</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12/7</u> 19 <u>57</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John H. Shaw</u>				M.D. <u>5800 Edmondson Ave. # 28</u>			
PHYSICIAN'S NAME (Type) <u>John H. Shaw, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Leah M. Kupper</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S.

1871

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12838 CERTIFICATE OF DEATH

12827  
Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>921 ELLENDALE DRIVE</b>		d. STREET ADDRESS <b>921 ELLENDALE DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>EVELYN C MAST</b>		4. DATE OF DEATH <b>DEC 13 1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1916</b>
9. AGE (In years last birthday) <b>41</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>C. Elmer Blakeley</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. Finn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>John Mast, Providence, Maryland</b>	
17. INFORMANT <b>John Mast, Providence, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>AD</b> DUE TO (c) <b>ADENOCARCINOMA OF OVARY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b> <b>14 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/24</b> , 1957, to <b>12/13</b> , 1957, that I last saw the deceased alive on <b>12/12</b> , 1957, and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald L. Somerville</b> M.D. <b>25 W. Pa. Ave.</b>		ADDRESS (Street, city or town, state) <b>Towson 4 Md</b>	
PHYSICIAN'S NAME (Type) <b>DONALD L. SOMERVILLE</b>		DATE SIGNED <b>12/13/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 16, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>		ADDRESS <b>Towson, Md.</b>	
24a. REC'D BY REGISTRAR <b>Dec. 15, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C Gray</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

1917



12828

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be filed with the local health department. Pages 1 and 2 should be filed with the local health department prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 10</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sheppard Enoch Pratt Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Branch McAdams</b>		4. DATE OF DEATH Month Day Year <b>Dec. 31 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 12, 1879</b>
9. AGE (In years last birthday) <b>78</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President Union Trust</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>	
11. BIRTHPLACE (State or foreign country) <b>Richmond Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George B. McAdams</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Reade Branch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Term.</b> <b>3 yr +</b> <b>3 yr +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to Senile Brain Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>55</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 18, 1956</b> to <b>Dec 31, 1957</b> , that I last saw the deceased alive on <b>Dec 31, 1957</b> , and that death occurred at <b>1:05 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. W. Edgin</b>		DATE SIGNED <b>1/1/58</b>	
PHYSICIAN'S NAME (Type) <b>W. W. Edgin</b>		ADDRESS (Street, city or town, state) <b>Sheppard Pratt Hosp. Towson - 4, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-3-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hollywood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Richmond, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co., Inc.</b>		24a. REC'D BY REGISTRAR <b>1 JAN 5 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Marie Gray</b>			

CHIEF V. S.

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TO REGISTERING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12840  
CERTIFICATE OF DEATH

12829

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>		c. LENGTH OF STAY IN 1b <b>x2 Glyndon</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 Central Ave.</b>		d. STREET ADDRESS <b>5 Central Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>J. McDonnell</b> Last		4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1896</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employed by Baltimore County</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James P. McDonnell</b>		14. MOTHER'S MAIDEN NAME <b>Julia Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <b>Yes W.W.1</b>		16. SOCIAL SECURITY NO. <b>220-12-5956</b>	
17. INFORMANT <b>Mrs. Margaret G. McDonnell, Glyndon, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4 a.o.i.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic C-V Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>10 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>7-31-47</b> , 19 <b>12-14-57</b> , 19 <b>10:30 P</b> , that I last saw the deceased alive on <b>12-14-57</b> , 19 <b>10:30 P</b> , and that death occurred at <b>10:30 P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b> DATE SIGNED <b>12-16-57</b>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. <b>6 Hanover Rd.</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 18, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>All Saints</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>12-16-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

BUREAU V. E.

DEC 1957

RECEIVED

Item: 16 Film G223 12/10/57 SH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Res. dence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>				c LENGTH OF STAY IN 1b <b>BALTIMORE</b>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d STREET ADDRESS <b>120 LANVALE ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>DAVID</b> Last <b>McFADDEN</b>		4. DATE OF DEATH Month <b>12</b> Day <b>4</b> Year <b>1957</b>					
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/9/18</b>	9. AGE (In years last birthday) <b>39</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REAL ESTATE BROKER</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>ALBERT D. McFADDEN</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN BURNS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <b>214-03-1574</b>		17 INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS ACTIVE</b> <b>FAR ADVANCED</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 months</b> DOXA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FATTY DEGENERATION OF LIVER</b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/30</b> , 1957, to <b>12/4</b> , 1957, that I last saw the deceased alive on <b>12/3</b> , 1957, and that death occurred at <b>12:05 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Buried Dec 7/17</b>		22b DATE THEREOF <b>Dec 7/17</b>		22c NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		22d LOCATION (City, town, or county) (State) <b>Beltsville, Md</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Steele &amp; Sons</b>				ADDRESS <b>1001 North 13th St</b>		24a REC'D BY REGISTRAR <b>DEC 6 1957</b>	
				24b REGISTRAR'S SIGNATURE <b>Shirley Newell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LIBRARY  
DEC 2 1957

## 12842 CERTIFICATE OF DEATH

1283131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1917 Hillside Ave.</u>		d. STREET ADDRESS <u>1917 Hillside Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha E. McGinnis</u>		4. DATE OF DEATH Month Day Year <u>Dec. 24 1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Balto.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Vernon Saker</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Mr. Wm. G. McGinnis Jr. - 6411 Kriebel Ave.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>421.1</u> DUE TO <u>Acute Pulmonary Edema</u> <u>Calapic Aortic Disease &amp; Aortic Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hour</u> <u>3 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-2</u> 19 <u>55</u> to <u>12-24</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12-23</u> 19 <u>57</u> , and that death occurred at <u>4:15 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon Ashman</u>		M.D. <u>5907 Gwynn Oak Ave. #7</u> 12-24-57	
PHYSICIAN'S NAME (Type) <u>Leon Ashman</u>		<u>5907 Gwynn Oak Ave. #7</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 28, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Randlettown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. H. M. Martin</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 20 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12832  
12843 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <b>Ethel Regina MCNAMEE</b>		2. DATE OF DEATH <b>Dec. 26, 1957</b>	
3. PLACE OF DEATH <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; London or A STATE B COUNTY before admission) <b>Maryland Baltimore Co.</b>	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <b>424 Overbrook Road</b>		6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
7. STREET ADDRESS (If rural, give location) <b>424 Overbrook Road</b>		8. DATE OF BIRTH <b>Oct. 26, 1897</b>	
9. LENGTH OF STAY IN BALTIMORE <b>Life</b>		10. AGE (last birthday) Under 1 Year Months: Days Hours: Min. <b>60</b>	
11. SEX <b>Female</b>	12. COLOR OR RACE <b>White</b>	13. SINGLE MARRIED WIDOWED DIVORCED (Specify) <b>Married</b>	14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
15. 1A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		16. 1B KIND OF BUSINESS OR INDUSTRY <b>----</b>	
17. 13 FATHER'S NAME <b>William J. McLaughlin</b>		18. 14 MOTHER'S MAIDEN NAME <b>Marv E. Doyle</b>	
19. 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <b>No</b>		20. 16 SOCIAL SECURITY NO <b>None</b>	
21. 17 INFORMANT <b>Mr. Joseph P. McNamee</b>		22. ADDRESS <b>424 Overbrook Road</b>	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) Carcinoma of colon with metastasis</b>		
DUE TO <b>metastasis</b>		
19. 15 3X ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST <b>(B) DUE TO</b>		
<b>(C) DUE TO</b>		

20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		21. 19A DATE OF OPERATION <b>Dec 21</b>		22. 19B CONDITION FOR WHICH OPERATION WAS PERFORMED <b>21E INJURY OCCURRED</b>		23. 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IF OPERATION WAS RELATED TO CAUSE OF DEATH ENTER IN PART I OR PART II 21D TIME (Month) (Day) (Year) (Hour) <b>21D TIME (Month) (Day) (Year) (Hour)</b>		24. 21E INJURY OCCURRED <b>21E INJURY OCCURRED</b>		25. 21F HOW DID INJURY OCCUR <b>21F HOW DID INJURY OCCUR</b>			

22. I certify that (I) (this hospital) attended the deceased from 19... to 19... that (I) (we) last saw the deceased alive on 19... and that death occurred at ... m., from the causes and on the date stated above.

23A. SIGNATURE <b>Doy E. Saylor</b>	23B. ADDRESS <b>M.D.</b>	23C. DATE SIGNED <b>12/27/57</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/30/57</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery Baltimore, Maryland</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
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25. DATE RECEIVED BY LOCAL REGISTRAR <b>DEC 29 1957</b>	26. REGISTRAR'S SIGNATURE <b>John A. Moran</b>	27. FUNERAL DIRECTOR <b>John A. Moran-3000 E. Baltimore St.</b>	28. ADDRESS <b>3000 E. Baltimore St.</b>
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THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the cause of death clearly and legibly. This certificate must be with the BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

RECEIVED

JAN 2 9

BUREAU V.

12844

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orwings Mills, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>5 yrs.</u>		d. STREET ADDRESS <u>3815 Monterey Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margay</u> Middle <u>Louise</u> Last <u>Meinert</u>		4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/47</u>
9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jerome Eugene Meinert</u>		14. MOTHER'S MAIDEN NAME <u>Georigeanna Austin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Spastic Infantile Paralysis</u> DUE TO (c) <u>since birth</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/30</u> , 19 <u>57</u> to <u>12/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/30</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12/31/57</u>			
ACTUAL SIGNATURE <u>Olive Reid Harris, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Olive Reid Harris, M.D.</u> <u>Rosewood State Training School</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>	22b. DATE THEREOF <u>12. 31. 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gr. of Md. Med. School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.H. Newell Inc. - Pikesville</u>		24a. REC'D BY REGISTRAR <u>Mary Elene</u> 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 3 1939

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12845 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# 12834

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;">Baltimore</span> <span style="margin-left: 100px;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="margin-left: 20px;">Maryland</span> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 40px;">Catonsville</span>			c. LENGTH OF STAY IN 1b <span style="margin-left: 20px;">29yr6mth26dys</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 40px;">Baltimore</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="margin-left: 20px;">SPRING GROVE STATE HOSPITAL</span>				d. STREET ADDRESS <span style="margin-left: 40px;">1006 Hanover Street</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="margin-left: 40px;">Anna</span> Middle <span style="margin-left: 40px;">Moffitt</span> Last				<b>4. DATE OF DEATH</b> Month <span style="margin-left: 20px;">December</span> Day <span style="margin-left: 20px;">3</span> Year <span style="margin-left: 20px;">19 57</span>			
5. SEX <span style="margin-left: 20px;">female</span>		6. COLOR OR RACE <span style="margin-left: 20px;">white</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="margin-left: 40px;">2-10-??</span>	
9. AGE (In years last birthday) <span style="margin-left: 20px;">82? yrs.</span>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="margin-left: 40px;">housewife</span>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="margin-left: 40px;">unknown</span>		12. CITIZEN OF WHAT COUNTRY? <span style="margin-left: 40px;">U. S. A.</span>			
13. FATHER'S NAME <span style="margin-left: 40px;">George Rollhoff</span>				14. MOTHER'S MAIDEN NAME <span style="margin-left: 40px;">Anna ??</span>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <span style="margin-left: 20px;">no</span>		16. SOCIAL SECURITY NO. <span style="margin-left: 40px;">unknown</span>		17. INFORMANT Address <span style="margin-left: 20px;">Records ; SPRING GROVE STATE HOSPITAL</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 20px;">900.7</span> <span style="margin-left: 20px;">Acute cardiac failure</span> DUE TO <span style="margin-left: 20px;">(b) Acute vascular disease</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="margin-left: 20px;">(c) fracture left hip</span> <span style="margin-left: 20px;">accident</span> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18). <span style="margin-left: 20px;">on way to cafeteria sustaining fractured left hip.</span>					
20c. TIME OF INJURY Month, Day, Year Hour <span style="margin-left: 20px;">6:45</span> <span style="margin-left: 20px;">P.M.</span> <span style="margin-left: 20px;">11-20-57</span>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <span style="margin-left: 20px;">Hospital</span>		20f. (City or town) (County) (State) <span style="margin-left: 20px;">Catonsville 28, Md.</span>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <span style="margin-left: 20px;">George M. Kieffer</span> M.D. EXAMINER'S NAME (Type) <span style="margin-left: 20px;">George M. Kieffer, M. D.</span>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <span style="margin-left: 20px;">BURIAL</span>				22b. DATE THEREOF <span style="margin-left: 20px;">12-6-57</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="margin-left: 20px;">NEW CATHEDRAL CEM</span>	
22d. LOCATION (City, town, or county) (State) <span style="margin-left: 20px;">BALTO</span>				22e. OLD FREDERICK RD. MD			
23. FUNERAL DIRECTOR'S SIGNATURE <span style="margin-left: 20px;">Charles J. Seiler</span>				ADDRESS <span style="margin-left: 20px;">4015 CONKLING ST. BALTO, 24, MD.</span>		24a. REC'D BY REGISTRAR DATE <span style="margin-left: 20px;">DEC 9 '57</span>	
24b. REGISTRAR'S SIGNATURE <span style="margin-left: 20px;">[Signature]</span>				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THOMAS V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12846 CERTIFICATE OF DEATH

1283538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>				d. STREET ADDRESS <b>315 E. North Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>SARA</b> Middle <b>ROBERTA</b> Last <b>MOONEY</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 10, 1876</b>	
9. AGE (In years last birthday) <b>81</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Miles</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth McFarland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>---</b>		17. INFORMANT <b>Mr. Nelson F. Hurley - 411 Hollen Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Arteriosclerosis</b> DUE TO (c) <b>Indefinite</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Nov 22, 1957</b> to <b>Dec 11, 1957</b> , that I last saw the deceased alive on <b>Fri Dec 6th 1957</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>2818 St Paul St Balto Md</b> DATE SIGNED <b>Dec 13 57</b>							
ACTUAL SIGNATURE <b>Nathaniel M Beck</b>				PHYSICIAN'S NAME (Type) <b>Nathaniel M Beck</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stim E. Lippner &amp; Sons - Balto</b>				24a. REC'D BY REGISTRAR DATE <b>12/13/57</b>		24b. REGISTRAR'S SIGNATURE <b>Michael Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NO. 1

RECEIVED



12847

CERTIFICATE OF DEATH

12836

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2mths20dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>415 Augusta Ave.</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Neuman</b> Last <b>Muhlbauer</b>				4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June, 1873</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Catonsville, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pyelonephritis</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour e. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept. 25, 1957</b> , to <b>Dec. 15, 1957</b> , that I last saw the deceased alive on <b>Dec. 15, 1957</b> , and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>12-15-57</b> ACTUAL SIGNATURE <b>Stella Wachslar</b> M. D. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REPOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<b>Burial</b>		<b>12-19-1957</b>		<b>ST. MATTHEWS CEM.</b>		<b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Truman Schuch</b> <b>3512 Frederick Ave. (29)</b>				24a. REC'D BY REGISTRAR <b>DEC 17 57</b>		24b. REGISTRAR'S SIGNATURE <b>Outreach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12848 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson, Balto., 4</b> c. LENGTH OF STAY IN 1b <b>Approx. 2 1/2 yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>117 Stevenson Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Beatrice Murray</b>				4. DATE OF DEATH Month Day Year <b>December 10 19 57</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 14, 1880</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John McGinnis</b>			
14. MOTHER'S MAIDEN NAME <b>Catherine Mulligan</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Admission Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency from</b> DUE TO <b>Generalized Arteriosclerosis</b> (c) <b>8 Yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>2 Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1955</b> to <b>December 1957</b> , that I last saw the deceased alive on <b>December 10, 1957</b> , and that death occurred at <b>117 Stevenson Lane</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>				ADDRESS (Street, city or town, state) <b>7501 York Rd Towson, Md</b>			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>				DATE SIGNED <b>12/10/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOS. TEXAS</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles F. O'Donnell M.D.</b>				24a. REC'D BY REGISTRAR <b>DATE 12/11/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

RECEIVED  
DEC 11 1957  
BUREAU V. S.

Reg. Dist. No. **12838**

~~DEC 20 57~~

U.S. DEPARTMENT OF JUSTICE

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12850 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

128314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Evering Mills</u>		c. LENGTH OF STAY IN 1b <u>18 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Evering Mills</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2002 Park Rd.</u>				d. STREET ADDRESS <u>2002 Park Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH PETER NAWROT</u>				4. DATE OF DEATH Month Day Year <u>Dec 4 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 14, 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Prod. Road</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Simon Luke Nawrot</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Stokaj</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1916</u>		16. SOCIAL SECURITY NO. <u>710-09-6425</u>		17. INFORMANT <u>Bridget Nawrot</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>18 min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. D. Catles</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>E. D. CATLES</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		11-4 1957	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>		22d. LOCATION (City, town, or county) (State) <u>Holbrook, Balt. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Wright</u>				24a. REC'D BY REGISTRAR <u>DEC 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

PLUMMER A. C.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, Film G-224 1/6/58. **CERTIFICATE OF DEATH**

Reg. Dist. No.

12840

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		d. STREET ADDRESS <b>2547 W. Fairmount Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>G.</b> Last <b>NEUBAUER</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>29,</b> Year <b>19 57</b>	
5. SEX <b>Male</b> <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>die maker</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>George Neubauer</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA.</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NO</b>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>0 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>DEC. 24, 1957</b> , to <b>DEC. 29, 1957</b> , that I last saw the deceased alive on <b>DEC. 24, 1957</b> , and that death occurred at <b>10: A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6348 FREDERICK ROAD, CATONSVILLE BALTIMORE 28 MD</b> DATE SIGNED			
ACTUAL SIGNATURE <b>S. Lloyd Johnson</b> M.D.		PHYSICIAN'S NAME (Type) <b>S. LLOYD JOHNSON, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/1/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. J. Tichner &amp; Son</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 2 '57</b> 24b. REGISTRAR'S SIGNATURE <b>Dee. Smith</b>	

RECEIVED

NOV 19 1964

12841

## 12852 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>207 S. Woodwell Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Winifred</b> Middle <b>Oberholtzer</b> Last <b>Oberholtzer</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1893</b>
9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James L. THOMAS</b>		14. MOTHER'S MAIDEN NAME <b>Winifred ? NOT KNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia - Congestive Failure - cystic Malnutrition</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 12, 1957</b> to <b>12-29, 1957</b> , that I last saw the deceased alive on <b>12-29, 1957</b> , and that death occurred at <b>11:40 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Eugene Watermann</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>12-29-57</b>	
PHYSICIAN'S NAME (Type) <b>C. Eugene Watermann</b>		<b>Catonsville 28, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>12/29/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WASHBURN ST. CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>SCRANTON PA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wiley Personal Home - Catonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>1958</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>U. H. Hedrick</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 8 1901

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Item 9 343 322 1-7-58 et  
12853 CERTIFICATE OF DEATH

128423 8

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wash</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6072 Falls Road</u>				d. STREET ADDRESS <u>6072 Falls Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Pahl</u>				4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>47</u> Min <u>3</u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Peter Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Helena A. Kluth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Arnold Hust, 6072 Falls Road</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 1, 1957</u> to <u>Dec. 28, 1957</u> , that I last saw the deceased alive on <u>Dec. 27, 1957</u> , and that death occurred at <u>5:30 P. M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Reuben Hoffman</u>				M.D. <u>846 W. 36th St., Baltimore, MD</u> <u>12/30/57</u>			
PHYSICIAN'S NAME (Type) <u>REUBEN HOFFMAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Justin E. Donovan - 3818 Roland Ave</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 11 1964

DEC 11 1964

RECEIVED  
FBI  
NOV 11 1964

12854

## CERTIFICATE OF DEATH

12843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>20 Owings Mills</b>	
f. STREET ADDRESS <b>72 Ritters Lane</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Adam</b> Last <b>Pape</b>		4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1884</b>
9. AGE (In years last birthday) <b>73</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Pape</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Knell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>			
DUE TO <b>Generalized arteriosclerosis</b>			
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 13, 19 57</b> , to <b>Dec. 5, 19 57</b> , that I last saw the deceased alive on <b>Dec. 5, 19 57</b> , and that death occurred at <b>8:30a. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslor</b>		DATE SIGNED <b>12-5-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslor, M. D.</b>		<b>Catonsville 28k Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-7-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers Home - Pikesville Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 13 57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1957

1957

RECEIVED



## 12855 CERTIFICATE OF DEATH

12844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>3yr9mth11dys</b>		d. STREET ADDRESS <b>4663 Pimlico Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>T.</b> Last <b>Paper</b>		4. DATE OF DEATH Month <b>12-</b> Day <b>25-</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. ?, 1889</b>
9. AGE (In years last birthday) <b>68 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b> ✓	
13. FATHER'S NAME <b>Muttel Faigenbaum</b>		14. MOTHER'S MAIDEN NAME <b>Schandel Wasselman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 20</b> , 19 <b>57</b> , to <b>12/25</b> , 19 <b>57</b> that I last saw the deceased alive on <b>12/25</b> , 19 <b>57</b> , and that death occurred at <b>10:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>STELLA WACHSLER M.D. SPRING GROVE STATE HOSPITAL 12/25/57</b>			
ACTUAL SIGNATURE <b>STELLA WACHSLER</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b> <b>12/25/57</b>			
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>12-26-57</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Rosedale</b>		<b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewne</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 27 '57</b>	
ADDRESS <b>2100 Capitol Place</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 1961

FURNACE NO. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12856 CERTIFICATE OF DEATH

12845

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>				d. STREET ADDRESS <b>2414 St. Paul Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Wheeler</b> Last <b>Patterson</b>				4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1876</b>		9. AGE (In years last birthday) <b>81</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph C. Wheeler</b>				14. MOTHER'S MAIDEN NAME <b>Sophia B. Medinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Miss Dorothy B. Schneider 2414 St. Paul St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>47 X</b> DUE TO <b>Bilateral Virus Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 days</b> (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb. 1</b> , 19 <b>57</b> , to <b>Dec. 26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 25</b> , 19 <b>57</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John F. Schaeffer</b>				M.D. <b>401 Ransom Road Baltimore 29</b>		DATE SIGNED <b>Dec. 27, 1957</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 28, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>				ADDRESS <b>1217 St. Paul Street</b>		24a REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE <b>DEC 30 '57</b>	

BUREAU W. F.

1957

RECEIVED

## 12857 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE-COUNTY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIDGEWAY MANOR HOME</u>			d. STREET ADDRESS <u>4711 Frederick Ave.</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH PEDDICOORD</u>			4. DATE OF DEATH Month Day Year <u>DEC 24, 1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 17, 1906</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>JOHN J. MURPHY</u>			14. MOTHER'S MAIDEN NAME <u>MARY BAKER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. AGNES M. REITZ</u> Address <u>4711 Frederick Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153X</u> DUE TO <u>Generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma, Colon</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Oct 4</u> 19 <u>57</u> , to <u>Dec 24</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 24</u> 19 <u>57</u> , and that death occurred at <u>11:40 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John F. Slegger</u> M.D.			ADDRESS (Street, city or town, State) <u>401 Brandon Road</u> DATE SIGNED <u>Dec 27, 1957</u>		
PHYSICIAN'S NAME (Type) <u>Baltimore 29</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Bur. Balto. Md.</u>	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Truman Schuch</u>			ADDRESS <u>3512 Frederick Ave. (29)</u>		
24a. REC'D BY REGISTRAR <u>DATE 30 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Rehman</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1967

25

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1284744  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beth Steel Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barto.</u>	
3. NAME OF DECEASED (Type or print) First <u>MANFIELD</u> Middle <u>—</u> Last <u>PERKINS</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>BL.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Hooker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Shipyard</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>ANNIE PERKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Mary Perkins</u> Address <u>6 N. Bond St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture of Skull</u> 910.3 DUE TO <u>Left Fronto-Parietal Area</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, of item 18.) <u>Fallen Ship Plate Crushed head between Plate + Car</u>	
20c. TIME OF INJURY Month <u>6</u> Day <u>4</u> Year <u>1957</u> Hour <u>—</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beth Steel Shipyard</u>	20f. (City or town) <u>Sparrows Pt Baltimore Md</u> (County) <u>—</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M B Davis</u> M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis M D</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>	22b. DATE THEREOF <u>12/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEM. LYNCHBURG VA.</u>	22d. (City or town) <u>—</u> (County) <u>—</u> (State) <u>VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELROY C WILSON</u> ADDRESS <u>1000 BRANTLEY AVE</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>	
		DATE <u>12/4/57</u>	

MEDICAL CERTIFICATION

U. S. A.

NO. 1

DELIVERED



## 12850 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home in the Green Stone</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesville</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth J. Foster</u>		d. STREET ADDRESS <u>5 Church Lane</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Nov 14, 1876</u>		9. AGE (In years last birthday) <u>81</u> yrs	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wine &amp; Hammer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Solovitz &amp; Co.</u>	
11. BIRTH PLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William H. Foster</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jacob</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>William H. Foster</u>		Address <u>525 Edgewood St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>			
DUE TO <u>Coronary disease</u>			
DUE TO <u>Myocardial infarction</u>			
DUE TO <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 10</u> 19 <u>50</u> to <u>Dec 12</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 11</u> 19 <u>57</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>JAMES W. KATZENBERGER</u>		ADDRESS (Street, city or town, state) <u>4123 1st St An</u>	
PHYSICIAN'S NAME (Type) <u>James Katzenberger</u>		DATE SIGNED <u>12/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem</u>		22d. LOCATION (City, town, or county) (State) <u>3801 Federal Ave</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan &amp; Son</u>		ADDRESS <u>2111 N. St</u>	
24a. REC'D BY REGISTRAR <u>DEC 16 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12849

12728 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4215 Kensington Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William H.</u> Middle <u>Powell</u> Last <u>Powell</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Compositor</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Compositor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Sun Papers</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Josiah Powell</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Gossnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>213-02-2729</u>	
17. INFORMANT <u>Mary E. Powell</u>		Address <u>4215 Kensington Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, arteriosclerotic (C.V. Disease)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>Dec. 30</u> , 1957, that I last saw the deceased alive on <u>Dec. 29</u> , 1957, and that death occurred at <u>8:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Paulician</u> M.D.		ADDRESS (Street, city or town, state) <u>4201 Walker, N. Baltimore, Md</u>	
PHYSICIAN'S NAME (Type) <u>John F. Paulician</u>		DATE SIGNED <u>1/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-3-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hulbard</u>		ADDRESS <u>4107 Wilkens Avenue</u>	
24a. REC'D BY REGISTRAR <u>1/3/58</u>		24b. REGISTRAR'S SIGNATURE <u>J. G. Gossnell</u>	

RECEIVED

JAN 1

BUREAU V. S.

## 12860 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex-Bowley's Quarters</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex -- Bowleys Quarters</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 15, Box 722</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BARBARA</b> Middle <b>JEAN</b> Last <b>PLYE</b>				4. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4, 1942</b>		9. AGE (In years last birthday) <b>15</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Listie, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John R. Pyle</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Whitfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John R. Pyle</b>		Address <b>Seneca Road Box 722 (20)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma-tosis</b> <b>146x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sarcoma (Bone)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-24</b> , 19 <b>57</b> , to <b>12-24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12-24-57</b> , 19 <b>57</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Marion A. Goldstein</b> M.D. (University Hospital)							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 27, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>				ADDRESS <b>1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>DEC 30 1957</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

, 12861 CERTIFICATE OF DEATH

12851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wiles Road</u>				d. STREET ADDRESS <u>Wiles Road</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Godwin</u> Last <u>Quillin</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1888</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Quillin</u>				14. MOTHER'S MAIDEN NAME <u>MARY GODWIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>418-03-0005</u>		17. INFORMANT <u>Stella J. Quillin</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal hemorrhage</u> DUE TO <u>metastatic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary site undetermined</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 mins.</u> <u>6 mos.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>434 Eastern Ave</u> DATE SIGNED <u>12/18/57</u> ACTUAL SIGNATURE <u>J. Platt, M.D.</u> M.D. <u></u> PHYSICIAN'S NAME (Type) <u>J. PLATT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unknown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Platt</u> ADDRESS <u>1407 Eastern Ave.</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>DEC 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 1967

RECEIVED



## 12862 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Conv. Home</u>				e. STREET ADDRESS <u>130 N. Luburn Ave</u>			
3. NAME OF DECEASED (Type or print) <u>MARY NELLIE RAPPANIER</u>				4. DATE OF DEATH <u>12/8/57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Kriete</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Bergner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Nora Kriete Kriete</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>  <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>2 September, 19 57</u> to <u>8 December, 19 57</u> that I last saw the deceased alive on <u>8 December, 19 57</u> and that death occurred at <u>10:30A M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Millard T. Traband, Jr.</u>				ADDRESS (Street, city or town, state) <u>5101 Gwynn Oak Ave. Balt. 7, Md.</u> DATE SIGNED <u>12/9/57</u>			
PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr. M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence</u>		22d. LOCATION (City, town, or county) <u>Balto. Co. Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McNabb &amp; Son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR <u>DEC 11 57</u>		24b. REGISTRAR'S SIGNATURE <u>Don</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1286 CERTIFICATE OF DEATH

1285378

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Towson</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eudowood - Towson 4, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>324 Hopkins Rd. Royal Fox</u>			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>LOUISE MARGRET RAYSINGER</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>21</u> Year <u>1957</u>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3/31/09</u>	
				<b>9. AGE</b> (In years for birthday) <u>48</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Legal Secretary</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Balt. Md</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>John Wm Raysinger</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Rita Stein</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <input type="checkbox"/> If yes, give war or dates of service <u>  </u>				<b>16. SOCIAL SECURITY NO</b> <u>213-05-6857</u>			
<b>17. INFORMANT</b> <u>Personal History</u> Address <u>Hospital Records, Eudowood Sanatorium</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Cervix - Inoperable</u> DUE TO <u>with metastases to adnexa +</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atrocien</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)			
<b>20c. TIME OF INJURY</b> Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>12-16</u> , 19 <u>57</u> to <u>12-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-20</u> , 19 <u>57</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>							
<b>ACTUAL SIGNATURE</b> <u>Milton B. Kress</u> M.D.				<b>Eudowood Sanatorium</b>			
<b>PHYSICIAN'S NAME</b> (Type) <u>Milton B. Kress, M.D.</u>				<u>Towson 4, Maryland</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b>		<b>22d. LOCATION</b> (City, town or county) (State)	
<u>12-24-57</u>		<u>Holy Redeemer</u>		<u>Balt. Md</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Kuck</u> ADDRESS <u>1305 Harbor</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DEC 21 1957</u>			
				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Markel Grays</u>			

BUREAU V. S.

1937

RECEIVED

12864 CERTIFICATE OF DEATH

12854

Reg. Dist. No.

1 PLACE OF DEATH o. COUNTY <b>Balto.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nurs. Ho.-100 N. Rolling Rd</b>		d. STREET ADDRESS <b>5006 Edmondson Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>REINHARDT</b> Last		4. DATE OF DEATH Month <b>Dec.</b> Day <b>8</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1901</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed-Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles W. Reinhardt</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Weber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Mrs. Freda Reinhardt - 5006 Edmondson Ave.</b>	
17. INFORMANT <b>Mrs. Freda Reinhardt - 5006 Edmondson Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis -</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive pneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>Mar 1, 1957</b> , to <b>Dec 8, 1957</b> , that I last saw the deceased alive on <b>Dec 8, 1957</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Howard H. Warner</b> M.D. <b>1604 Garrison Blvd.</b> PHYSICIAN'S NAME (Type) <b>HOWARD H. WARNER</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>12/11/57</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b> 22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Stan J. Tiekner &amp; Sons - Balto, Md.</b> ADDRESS 24a. REC'D BY REGISTRAR DATE <b>12/10/57</b> 24b. REGISTRAR'S SIGNATURE <b>R. H. Redmond</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12865

## CERTIFICATE OF DEATH

12855

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 14 Eastern Blvd.</u>				d. STREET ADDRESS <u>Box 14 Eastern Blvd.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Reinhardt</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14, 1869</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baliff-Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Reinhardt</u>				14. MOTHER'S MAIDEN NAME <u>Kate Haas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Christina League Box 14 Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio-vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct 14</u> , 19 <u>57</u> , to <u>Dec 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 11</u> , 19 <u>57</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>James H. White</u> M.D. <u>422 Eastern Ave. Baltimore 24008 Md.</u> PHYSICIAN'S NAME (Type) <u>James White</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Breaker Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u>DEG 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Newton L. Farber</u>	

U. S. A.

REC 111

RECEIVED



**12866**

**CERTIFICATE OF DEATH**

**128568**  
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1749 Forrest Avenue</u>				d. STREET ADDRESS <u>1749 Forrest Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mrs.</u> Middle <u>Della C.</u> Last <u>Revis</u>				4. DATE OF DEATH Month <u>December</u> Day <u>27th</u> Year <u>19 57</u>			
5 SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22, 1879</u>	
9 AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Asheville, N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13 FATHER'S NAME <u>Thomas Wheeler</u>				14 MOTHER'S MAIDEN NAME <u>Mary Banks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Oliver D. Revis, 1749 Forrest Ave</u>				Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u>							
DUE TO <u>myocardial infarction</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO (b) <u>hypertension</u>							
DUE TO (c) <u>generalized arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 15, 1949</u> to <u>Dec 27, 1957</u> , that I last saw the deceased alive on <u>Dec 27, 1957</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Donald W. Mintzer</u> M.D. <u>3009 EVERGREEN AVE BALTO 14 MD</u>							
PHYSICIAN'S NAME (Type) <u>Donald W. Mintzer</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road.</u>				24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bill M. Lacey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

EC 1057

BUREAU V. S.

12867

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
f. STREET ADDRESS <b>353 Rosebank Avenue</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>RHODES</b>				4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/26/89</b>	
9. AGE (In years last birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Refrigeration Man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Willis Rhodes</b>				14. MOTHER'S MAIDEN NAME <b>Mazie Moorehead</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>WWI</b>		17. INFORMANT <b>Clin.Rec.Div.Vets.Admin.Hospital,Ft.Howard,Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOMEGALY WITH HYPERTROPHY OF LEFT AND RIGHT VENTRICLES.</b> DUE TO <b>ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIAC VASCULAR AND RENAL DISEASES.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIAC VASCULAR AND RENAL DISEASES.</b> (c) <b>ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIAC VASCULAR AND RENAL DISEASES.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unknown.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that the deceased died on <b>December 14, 19 57</b> , at <b>Baltimore, Md.</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b> DATE SIGNED <b>12/21/57</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH Fort Howard, Maryland</b> PHYSICIAN'S NAME (Type) <b>Chien Wei LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-24-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National.</b>		22d. LOCATION (City, town, or county) (State) <b>5501 Frederick Ave., Balt., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight</b>				24a. REC'D BY REGISTRAR DATE <b>12/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	

Wm Cook-Blight Funeral Home 6089 Harford Road, Balto., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

DEC 30 1957

RECEIVED

## 12868 CERTIFICATE OF DEATH

12858 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>7</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>40 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>201 1st Street</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>F.</b> Last <b>RITTMAYER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1882</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>7</b> Days <b>5</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Police Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pajern, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Rittmeyer</b>		14. MOTHER'S MAIDEN NAME <b>Dora Shick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-24-6739</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE STOMACH</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>151X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p. m. <b>VA</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 24, 1957, to December 3, 1957</b> , and that death occurred at <b>1:25 A.M.</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>VAH Ft. Howard, Md</b>		DATE SIGNED <b>12/3/57</b>	
ACTUAL SIGNATURE <b>Irving Freeman</b>		M.D. <b>VAH Ft. Howard, Md</b>	
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D.,</b>		<b>VAH Ft. Howard, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/7/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Ritchie Hwy, Balto. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; Kirshner</b>		ADDRESS <b>421 Crain Hwy, Glen Burnie, Md.</b>	
24. REC'D BY REGISTRAR <b>DEC 6 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. E.

DEC 6 1957

100-100000-100000

## 12869 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>55yr6mth7dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>2306 Mt. Royal Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle Last <b>Rogers</b>				4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. <del>MARRIED</del> <b>WIDOWED</b>		8. DATE OF BIRTH <b>Sept. 25, 1874</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Mm.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>							
13. FATHER'S NAME <b>Morris Kenefsky</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Lechinsky</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Balto., Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Dec. 24</b> , 19 <b>57</b> , to <b>Dec. 31</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 31</b> , 19 <b>57</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
DATE SIGNED <b>12-31-57</b>							
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lechner &amp; Sons</b>				ADDRESS <b>118 Pear</b>		24a. REC'D BY REGISTRAR DATE <b>1/2/58</b>	
				24b. REGISTRAR'S SIGNATURE <b>R. W. Lechner</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

NOV 3 1970

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12860			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										12870			
Reg. Dist. No. 37													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hereford</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Monkton Road</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Hereford</b> d. STREET ADDRESS <b>1 Monkton Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>MARIE</b> Last <b>RUHL</b>					4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1957</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29, 1909</b>		9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Joshua Talbott Kelley</b>						14. MOTHER'S MAIDEN NAME <b>Mae Colgate</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Preston Ruhl, Monkton Rd., Hereford, Md.</b> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute extensive esophagitis and gastritis</b> 771-8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ingestion of pine oil deodorant compound</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.) <b>Ingestion of pine oil deodorant compound</b>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>12/9</b> 19 <b>57</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Baltimore</b> (County) <b>md.</b> (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <b>[Signature]</b> NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>12/9/57</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>May's Chapel Cemetery</b>				22d. LOCATION (City, town, or county) <b>Timonium, Maryland</b> (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> NAME (Type)				ADDRESS <b>Towson, Maryland</b>				24a. REC'D BY REG-STRAR <b>[Signature]</b> DATE <b>DEC 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

RECEIVED

DEC 19 1957

BUREAU V. B.

## 12871 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>831 Wildwood Parkway</b>			
3. NAME OF DECEASED (Type or print) First <b>EMIL</b> Middle <b>---</b> Last <b>SAAL</b>				4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1874</b>	
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant - Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Business</b>		11. BIRTHPLACE (State or foreign country) <b>Panora, Iowa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Doyasal Saal</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes SAW</b>				16. SOCIAL SECURITY NO. <b>--</b>			
17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURE OF ANEURYSM OF THE ABDOMINAL AORTA</b> DUE TO <b>ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UNKNOWN</b> DUE TO (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>December 16, 1957</b> to <b>December 17, 1957</b> and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>12/18/57</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>12-18-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Tarkio Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tarkio, Missouri</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook - Blight, Inc.</b> ADDRESS <b>Wm. Cook - Blight, Inc., 6009 Harford Rd., Baltimore 11 Md.</b>				24a. REC'D BY REGISTRAR <b>12/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>Newton L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

SHIPPED TO: John Davis Funeral Home, Tarkio, Mo.

BUREAU V. A.

DEC 30 1957

RECEIVED

12722

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist No

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Res. since before admission)		3. DATE OF DEATH		4. TIME OF DEATH	
Baltimore		Maryland		December 10		1957	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Dundalk				92 Dundalk Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				f. STREET ADDRESS			
92 Dundalk Avenue				92 Dundalk Avenue			
5. NAME OF DECEASED (Type or print)		6. SEX		7. COLOR OR RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
EDITH L. SAFLEY		Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday)		10. DATE OF BIRTH		11. AGE (In years last birthday)		12. IF UNDER 1 YEAR	
44 yrs.		March 25, '12		44 yrs.		Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
waitress		Bar Room		Virginia		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward Dough				Willie Groome			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
none				Chas. F. Safley Sr.		92 Dundalk Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy							
3503 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/10/57	
Paul F. Guerin, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-13-57		Hillcrest		Louisa, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard, 4107 Wilkens Ave				DATE 12-10-57		Mr. Kelly	

BUREAU V. S.

DEC 1 1957

RECEIVED

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River (20)		c. LENGTH OF STAY IN 1b Baltimore (13)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 185 Squehanna Avenue		d. STREET ADDRESS 3042 31st Mayfield Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last ROSE ANNA SCHLAUCH		4. DATE OF DEATH Month Day Year December 30 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1914
9. AGE (In years last birthday) 43 yrs		10. IF UNDER 1 YEAR Months Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Lisy		14. MOTHER'S MAIDEN NAME Marie Anna Sykora	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sebastian C. Schlauch, husband, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobar pneumonia, left lower lobe			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Apparently fell in water while in confused state due to pneumonia	
20c. TIME OF INJURY Month, Day, Year 12/30 1957	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water	20f. (City or town) Baltimore (County) Md. (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		DATE SIGNED 12/31/57	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/3/58	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral home 3331 Brehms Lane		24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Edith Turley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 3 1958

BUREAU V. S.

JAN 3 1900

RECEIVED



12873

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>BALTO,</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>7 mos. 15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE ST. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF (Type or print) <b>WILLIAM</b> First <b>SCHMIER</b> Middle <b>SCHMIER</b> Last		4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>1957</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-1887</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b>	
11 BIRTHPLACE (State or foreign country) <b>GERMANY Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY SCHMIER</b>		14 MOTHER'S MAIDEN NAME <b>CAROLINE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>UNKNOWN</b>	
17. INFORMANT <b>MRS. FRED. C. TYSON</b>		Address <b>4710 HADDON AVE BALT.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Infarction of Myocardium</b> DUE TO <b>Arteriosclerotic Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Hour <b>a</b> m <b>19</b> Month, Day, Year	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/23/57</b> 19 <b>12/8/57</b> 19 <b>12/8/57</b> , that I last saw the deceased alive on <b>12/8/57</b> , 19 <b>12/8/57</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Spring Grove St. Hosp. Bal</b> DATE SIGNED <b>12/8/1957</b>			
ACTUAL SIGNATURE <b>Bruno Radauskas</b>		PHYSICIAN'S NAME (Type) <b>Bruno RADAUSKAS</b>	
22a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b DATE THEREOF <b>12-10-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE</b>		22d LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>J.T. STANSBURY</b>		ADDRESS <b>6411 Windsor Mill</b>	
24a. REC'D BY REGISTRAR <b>DEC 11 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 could be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED U. S.

RECEIVED

## 12874 CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Augsburg Home - 6811 Campfield Rd.</b>		d. STREET ADDRESS <b>2117 Belair Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>SCHMITT</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1880</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gen'l. Agt. (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Asso. for Lutherans Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry C. Schmitt</b>		14. MOTHER'S MAIDEN NAME <b>Amelia R. Weyrich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>no</b> (If yes, give date of service)		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Mrs. Lillian Koletschke - 1636 Northgate Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>(1) - Cerebral Hemorrhage</b> DUE TO <b>301X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>21 Broncho - Pneumonia</b> DUE TO <b>-</b> (c) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>24 hrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>301X - Generalized Arterio - Sclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June - 1957</b> to <b>Dec. 13, 1957</b> , that I last saw the deceased alive on <b>Dec. 12 - 1957</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Chambers</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4108 Liberty Hts - Balto - Md - 12-13-57</b>	
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers -</b>		<b>4108 Liberty Hts. Ave - Balto - Md - 12-13-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/16/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichner</b>		23a. REC'D BY REGISTRAR <b>12/16/57</b>	
23b. REGISTRAR'S SIGNATURE <b>Jessie Powell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6 A 1120000

200

10/10/10

## CERTIFICATE OF DEATH

12866

Reg. Dist. No. ....

12875

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>1</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines 16 MUSTING AVE</u>				STREET ADDRESS (If rural give location) <u>120 S. CALHOUN ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLES C.</u> (Middle) <u>SCHREINER</u> (Last)				(Month) <u>DEC.</u> (Day) <u>9</u> (Year) <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JULY 7, 1886</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXTERMINATOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>PEST CONTROL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES SCHREINER</u>				14. MOTHER'S MAIDEN NAME <u>CHARA E. SCHEATER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u> <u>WORLD WAR I</u>			16. SOCIAL SECURITY NO. <u>212-20-7209</u>		17. INFORMANT & ADDRESS <u>MAMIE SMITH 2118 W BALTO. ST.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 da.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Epidermoid Carcinoma, Left Side of Tongue</u>						<u>5 mo.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-3</u> , 19 <u>57</u> , to <u>12-9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-9</u> , 19 <u>57</u> , and that death occurred at <u>11:55</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>William K. Jolley</u>				ADDRESS (Street, city, town, state) <u>M.D. 6209 Frederick Ave. Baltimore 28 Md.</u>		DATE SIGNED <u>12/12/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-12-57</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 12 '57</u>		REGISTRAR'S SIGNATURE <u>W. Jolley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwab</u>		ADDRESS <u>2101 Frederick Ave.</u>	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-1

BUREAU V. S.

NOV 11 1957

RECEIVED

12876

CERTIFICATE OF DEATH

12867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6637 Frederick Ave.</b>		d. STREET ADDRESS <b>6637 Frederick Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Schroeder</b> Last <b>Schroeder</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1874</b>
9. AGE (In years last birthday) <b>33</b> yrs		IF UNDER 1 YEAR Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min. <b>33</b>	IF UNDER 24 HRS. Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min. <b>33</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Md.</b>	
13. FATHER'S NAME <b>Fred. Von Lindenberg</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mrs. Murray Harrison</b>		Address <b>6637 Fred. Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral. Arterio Sclerosis.</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>334X</b> DUE TO (c) <b>334X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 1, 1957</b> to <b>Dec. 29, 1957</b> , that I last saw the deceased alive on <b>Dec. 26, 1957</b> , and that death occurred at <b>30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1905 W. Baltimore St. Balto. Md.</b> DATE SIGNED <b>1957</b>			
ACTUAL SIGNATURE <b>Daniel E. Bogorad</b> M.D.		PHYSICIAN'S NAME (Type) <b>DANIEL E. BOGORAD M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>12-31-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn XXX Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home Catonsville Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 3 1958</b>	24b. REGISTRAR'S SIGNATURE <b>U. H. Hedrick</b>

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 10 1901

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for use by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for X-ray files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12877

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12868  
Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>234 E. SUSQUEHANNA AVE</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWSON</b>			
f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>234 E. SUSQUEHANNA</b>				g. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>R.</b> Last <b>SCHROEDER</b>				4. DATE OF DEATH Month <b>DEC</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV 1, 1916</b>	
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>NY</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>UNKNOWN CLEVE</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT (Address) <b>MENIVETH (Husband)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT LOWER</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>DUE TO</b> cause listed. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 2, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons</b>				ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 2 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>Hubert Gray</b>			

DATE SIGNED  
**12/30/57**

BUREAU V. S.

JAN 2 1917

RECEIVED



BUREAU V. 3

JAN 2 1959

RECEIVED  
JAN 2 1959

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM-3. Page 5 may be retained for separate files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12879

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 223 12-30-57 et

12870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>11mth5dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Maryland Washington 27,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>5900 Addison Rd., S. E.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Elizabeth</b> Last <b>Sherman</b>				4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1887</b>		9. AGE (in years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown WALTER TUCKER</b>				14. MOTHER'S MAIDEN NAME <b>Unknown MARGARET CROSBY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown NONE</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cor. failure</b> 9047 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic Cardio-vascular disease</b> DUE TO (c) <b>fracture left femur Accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>operation for fracture sigmoid prior</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>by another patient on 8-19-57 sustaining an intertrochanteric fracture of left femur</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>4:30</b> P. M. <b>8-19 19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) (County) (State) <b>Catonsville 28, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Geo M. Kieffer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or DISPOSAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-14-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Friendship, Meth. dist Church Friendship</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., Riverdale, Md.</b>				24a. RECEIVED BY REGISTRAR <b>DEC 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

BUREAU V. 2

DEC 7

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12880

CERTIFICATE OF DEATH

12871

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>90 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer Park Road</u>		d. STREET ADDRESS <u>1 Deer Park Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE ANN SHIPLEY</u>		4. DATE OF DEATH Month Day Year <u>December 23 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) <u>90</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry E. Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Frederick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Ann Murray, Reisterstown</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> (c) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December 17, 1957</u> , to <u>December 23, 1957</u> , that I last saw the deceased alive on <u>December 23, 1957</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cassius P. McKeever</u> M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u> DATE SIGNED <u>Dec 23/57</u>	
PHYSICIAN'S NAME (Type) <u>Cassius P. McKeever</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 26-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Berryman &amp; Sons</u> ADDRESS <u>Reisterstown</u>		24a. REC'D BY REGISTRAR <u>DATE 12-26-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary B. Elin</u>

RECEIVED

DEC 3 1937

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12881

## CERTIFICATE OF DEATH

12872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines Convalescent Home</u>				d. STREET ADDRESS <u>5501 Ashbourne Road</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>D.</u> Last <u>Sigler</u>				4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/1891</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
13. FATHER'S NAME <u>James D. Sigler</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>W.W. I</u>				16. SOCIAL SECURITY NO. <u>W.W. I</u>			
17. INFORMANT <u>Mary E. O'Leary - 1521 Arbutus Avenue</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Renal insufficiency</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular disease</u> DUE TO (c) <u>Chronic Malacia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Malacia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12</u> <u>21</u> <u>1957</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Catonsville</u> (County) <u>3rd</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>Dec 20</u> , 19 <u>57</u> , to <u>Dec 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>57</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>910 W. Lombard St. Baltimore Md.</u> DATE SIGNED <u>Dec 27/57</u>							
ACTUAL SIGNATURE <u>Charles J. Tommasello</u> M.D.				DATE SIGNED <u>Dec 27/57</u>			
PHYSICIAN'S NAME (Type) <u>Charles J. Tommasello</u> MD				ADDRESS <u>910 W. Lombard St. Baltimore Md.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George P. Miller Jr.</u> ADDRESS <u>5713 First Ave. - 27</u>				24a. REC'D BY REGISTRAR <u>DEC 28</u> DATE		24b. REGISTRAR'S SIGNATURE <u>mail</u>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD V. S.

DEC 22 1961

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12882

CERTIFICATE OF DEATH

12873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>B.</b> Last <b>SISSON</b>		4. DATE OF DEATH Month <b>12</b> / Day <b>16</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/22/1869</b>
9. AGE (In years last birthday) <b>88 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>LOUIS Sisson</b>		14. MOTHER'S MAIDEN NAME <b>Willie Webb</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>220-07-53484</b>	
17. INFORMANT <b>Hospital Record.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>many years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>probably several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 19, 1957</b> , to <b>Dec 16, 1957</b> , that I last saw the deceased alive on <b>Dec 16, 1957</b> , and that death occurred at <b>7:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Spring Grove State Hosp. Catonsville 28 Md</b> DATE SIGNED <b>12/16/57</b>			
ACTUAL SIGNATURE <b>Bruno Radauskas</b>		PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/19/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Road #14</b>	
24a. REC'D BY REGISTRAR <b>DEC 20 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Ruck</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BUREAU V. S.

187

RECEIVED

12883

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>		c. LENGTH OF STAY IN 1b <b>5mo 15days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b>	
3. NAME OF DECEASED (Type or print) <b>STEVEN</b> First <b>HAROLD</b> Middle <b>SMITH</b> Last		4. DATE OF DEATH <b>Dec 28 1957</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 20, 1948</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	9. AGE (In years last birthday) <b>9</b> yrs
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Hamman Smith</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Langford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>—</b>	
17. INFORMANT <b>Parents -</b>		Address <b>502 Zuckerman Ave Fort Benning, Georgia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia - bilat</b> <b>351X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Palsy and Epilepsy</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-13</b> , 19 <b>57</b> , to <b>12-28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec 28</b> , 19 <b>57</b> , and that death occurred at <b>12:31PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Olive Reid Harris</b> M.D. <b>Rosewood Training School</b>		ADDRESS (Street, city or town, state) <b>Owings Mills, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>OLIVE REID HARRIS</b>		DATE SIGNED <b>JAN 2 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/31/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank D. Newell, Pikesville, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 2 1958</b>	24b. REGISTRAR'S SIGNATURE <b>Mary Elmer</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 2 1977

BUREAU

12875  
Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>15y. 10mth 9dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Spring</u> Last <u>Spring</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-66</u>
9. AGE (In years last birthday) yrs. <u>91</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Spring</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Goldsmith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: Spring Grove Hospital</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>D Congestive failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular disease with myocardial hypertrophy and degeneration.</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>emphysema and chronic bronchitis malnutrition</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 17, 1957</u> to <u>Dec. 6, 1957</u> , that I last saw the deceased alive on <u>Dec. 6, 1957</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>C. Eugene Waterman</u> M.D.		SPRING GROVE STATE HOSPITAL <u>12-6-57</u>	
PHYSICIAN'S NAME (Type) <u>C. Eugene Waterman, M.D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Dec 10, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikeville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Berryman</u>		ADDRESS <u>Registration Md.</u>	
24a. REG'D BY REGISTRAR DATE <u>12-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Moore B. Shaw</u>	

U.S. AIR FORCE

DEC 1

11/24/50



12885

## CERTIFICATE OF DEATH

12876

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jane</b> Middle <b>Elizabeth</b> Last <b>Stocksdale</b>				4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 23, 1891</b>	
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>George Stocksdale</b>		14. MOTHER'S MAIDEN NAME <b>Annie Yax</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>214-03-5614</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> <b>4000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>congestive heart failure - 2 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 3, 1957</b> to <b>12-18, 1957</b> , that I last saw the deceased alive on <b>12-18, 1957</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED							
ACTUAL SIGNATURE <b>J. W. S. N. C. E. L. L. S. M. D.</b>				PHYSICIAN'S NAME (Type) <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>All Saints Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Berryman &amp; Sons</b>				ADDRESS <b>Reisterstown Md</b>		24a. REC'D BY REGISTRAR DATE <b>12-20-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary B. Elise</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC

BUREAU V. S.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the medical examiner's use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12886 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12877 44  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Sp. Pt.</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sparrows Point Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4	
f. STREET ADDRESS <b>1213 Mulberry Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>AARON</b> Last <b>STOKES</b>		4. DATE OF DEATH Month <b>12</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-7-91</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Stokes</b>		14. MOTHER'S MAIDEN NAME <b>Virginia A. Shelton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-9796</b>	
17. <b>DECEASED</b> Address <b>Bethlehem Steel Co. Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4:00 P.M.</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>NONE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>NONE</b> 19 p. m.		20d. INJURY OCCURRED While <b>NONE</b> at work <input type="checkbox"/> or while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, shop, office bldg., etc.) <b>NONE</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <b>M.B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>12-13-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-18-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel W. Sullivan Jr.</b>		ADDRESS <b>Baltimore, Md.</b>	
24a. RECD BY REGISTRAR <b>DEC 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Samuel L. Farber</b>	

BUREAU V. S.

DEC 16 1904

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12887

## CERTIFICATE OF DEATH

12878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				e. STREET ADDRESS <u>Seminary ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHARINE GUNTHER STRINGER</u>				4. DATE OF DEATH Month Day Year <u>Dec. 11, 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 5-1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Gunther</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Schleining</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		(If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>710</u>		17. INFORMANT Address <u>Mrs. Howard C. Marchant, 222 Oakdale Rd., Baltimore 19, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, site undetermined, probably lung.</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arterio-sclerotic Heart Disease; cerebral thromboses</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>Dec. 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 9</u> , 19 <u>57</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>6 E. Eager St., Baltimore</u>				DATE SIGNED <u>Dec. 12, 1957</u>			
ACTUAL SIGNATURE <u>Crawford N. Kieferbach, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Crawford N. Kieferbach, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons, Co.</u>				ADDRESS <u>4905 York Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 13 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Re-... ..</u>							

U. S. A. 1910.

NO. 1000

RECEIVED

FOR STATE  
HEALTH DEPT.

12888

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12879  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>2411 Rockwell Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>B.</b> Last <b>Sullivan</b>				4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 15, 1880</b>	
9. AGE (In years last birthday) <b>77</b> yrs		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>		IF UNDER 24 HR. Hours <b>7</b> Min <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer - Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co. Maryland</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Sullivan</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Bankard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>George S. Sullivan</b>		Address <b>2411 Rockwell Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>							
DOX DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetic Mellitus</b>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right leg amputated several years ago gangrene</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>GEO. S. M. KIEFFER</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>GEO. S. M. KIEFFER M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dec 7 57</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>				ADDRESS <b>1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>DEC 11 '57</b>	
						24b. REGISTRAR'S SIGNATURE <b>DeWard</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter as the cause of death "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPARTMENT OF JUSTICE

RECEIVED  
FEB 10 1964



## 12729 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands #27</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands #27</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2919 Georgia Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sophia</u> Middle <u>Temme</u> Last <u>Temme</u>		4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or date of service) <u>WWI</u>		16. SOCIAL SECURITY NO <u>220-30-6462</u>	
17. INFORMANT <u>Mrs. Matilda Temme</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Central Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2, 1955</u> to <u>Dec 7, 1957</u> that I last saw the deceased alive on <u>Dec 6, 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Schmfield</u> M.D.		ADDRESS (Street, city or town, state) <u>2301 Annapolis Rd</u> DATE SIGNED <u>Dec 12 1957</u>	
PHYSICIAN'S NAME (Type) <u>Paul Schmfield</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 19, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1524 Brighton</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Geo M. Kueffner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12881

12889

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGE-MERE</u>		c. LENGTH OF STAY IN 1b <u>9 WKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2528 HADDANAY RD.</u>				d. STREET ADDRESS <u>18 S. CATHERINE ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Matilda K. Thompson</u>				4. DATE OF DEATH Month Day Year <u>DEC. 31. 1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1891</u>		9. AGE (in years last birthday) <u>66</u> yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>WILHELMIA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN H. THOMPSON, 18 S. CATHERINE ST.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>45X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Sclerosis (far advanced)</u> DUE TO (c) <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured right hip.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1, 1957</u> to <u>Dec. 31, 1957</u> , that I last saw the deceased alive on <u>Dec. 31, 1957</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>914 D Street</u> <u>12/31/57</u> <u>Baltimore 19, Md.</u>							
ACTUAL SIGNATURE <u>Marion Owens</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Marion Owens</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR. 4101 EDMONDSON</u>				ADDRESS <u>4101 EDMONDSON</u>		24a. REC'D BY REGISTRAR <u>N 3 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Tom Kelly</u>			

RECEIVED  
JAN 5  
BUREAU V. S.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12890 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12882

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>116 E. Clement St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove Hospital</u>		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANTHONY B. THUMAN</u>		4. DATE OF DEATH <u>December 15 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/02</u>
9. AGE (in years, last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland Katz</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph</u>		14. MOTHER'S MAIDEN NAME <u>Mary Henneke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Family - Sane</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty Liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		DATE SIGNED <u>12/16/57</u>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>12/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes - 130 E. Fort Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 17 57</u>	
		24b. REGISTRAR'S SIGNATURE <u>  </u>	

3 17 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12891 CERTIFICATE OF DEATH

Reg. Dist. No. 128831

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - GRANITE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - GRANITE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>OLD COURT RD. - GRANITE</b>				d. STREET ADDRESS <b>OLD COURT RD. - GRANITE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELLEN ELIZABETH TRAIL</b>				4. DATE OF DEATH Month Day Year <b>DEC 30 1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 13, 1867</b>	9. AGE (In years last birthday) yrs. <b>90</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN A. THRIFT</b>				14. MOTHER'S MAIDEN NAME <b>MARY EMENIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>DAUGHTER - BEULAH GOSNELL</b>		Address <b>OLD COURT RD GRANITE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL EMBOLISM</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DEGENERATIVE HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>11 YEARS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 10, 1957</b> , to <b>DEC 30, 1957</b> , that I last saw the deceased alive on <b>DEC 29, 1957</b> , and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>8204 LIBERTY RD, BALTO MD 12/30/57</b>							
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b> M.D. <b>EDWIN L. PIERPONT</b>							
PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-2-58</b>		22c. NAME OF CEMETERY OR CREMATORY: <b>Granite Pres. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Granite, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Loring Byers, 8728 Liberty Rd., Randallstown, Md.</b>							
24a. REC'D BY REGISTRAR <b>JAN 2 1958</b>							
24b. REGISTRAR'S SIGNATURE <b>Dr. J. M. D. Martin</b>							

BUREAU V. S.

JAN 2

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12884

12892

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>				c. LENGTH OF STAY IN 1b <b>24 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRINGS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>ELDRID ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LUTHER</b> First <b>RUSSELL TYLER</b> Middle <b>TYLER</b> Last				4. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>6/30/1906</b>	
9. AGE (In years last birthday) <b>51</b> yrs		IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b></b> Min <b></b>		IF UNDER 24 HRS Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>LEXINGTON VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>SAM TYLER</b>				14. MOTHER'S MAIDEN NAME <b>RACHEL SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-141-473</b>			
				17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b> DUE TO (b) <b>Pulmonary Tuberculosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b> <b>5 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>X</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>4/25/57</b> , 19 <b>57</b> , to <b>12/19/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/14</b> , 19 <b>57</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b>							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>12.24.57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery, Baltimore, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Jewell, Silver Spring, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 12/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Elmer</b>	

REAU V. E.

DEC 30 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
 1. Give the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health,  
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2 '57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2650 W Park Drive</u>				d. STREET ADDRESS <u>2650 W. PARK DR.</u>			
3. NAME OF DECEASED (Type or print) <u>Anna A Wagner</u>				4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-02</u>		9. AGE (in years last birthday) <u>55</u> yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>WESTMINSTER</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARVEY RACINE</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>WM WAGNER 2650 W. PARK DR.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour _____ a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Wilmer K. Gallagher</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BLACK ROCK</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. STANSBURY</u>				24a. REC'D BY REGISTRAR <u>6 DEC 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur H. Marking</u>	

BALTO 7,

DEC 9 1957

RECEIVED

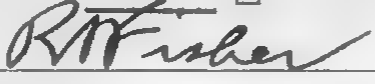

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12894 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1019 Mt. Holly Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MYRLE</b> Middle <b>BELL</b> Last <b>WALTZ</b>				4. DATE OF DEATH Month <b>December</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>April 24, 1896</b>	
9. AGE (last birth) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days		IF UNDER 24 HRS. Hours <b>60</b> Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Edgar Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Elsie B. Franklin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Quentin Gunn, Same as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		M.D. CHIEF MED CAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12/9/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-11-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Taylorsville</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 13 57</b>		24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

PORTLAND V. S.

EC 11 1967

NEGATIVE ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12895

CERTIFICATE OF DEATH

12887 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore 19</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>IN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>IN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Poplar Rd</u>		d. STREET ADDRESS <u># 1</u>	
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>L.</u> Last <u>WATKINS</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 11, 1911</u>
9. AGE (In years last birthday) <u>46</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>T. Bay Rochester</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Reid</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Marge Clark as in # 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adeno carcinoma rectum</u> DUE TO (b) <u>with generalized metastases</u> DUE TO (c) <u>Colostomy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 yrs</u> <u>6 months</u> <u>17 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1-</u> 19 <u>51</u> to <u>12/31</u> 19 <u>57</u> that I last saw the deceased alive on <u>12/30</u> 19 <u>57</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>6908 North Pt. Rd 12/31/57</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>		<u>Balto. 19-MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>1-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BIRMINGHAM ALABAMA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight</u>		ADDRESS <u>6009 Harford Road</u>	
24a. REC'D BY REGISTRAR <u>DATE 1/7/58</u>		24b. REGISTRAR'S SIGNATURE <u>Dwison L. Farley</u>	

RECEIVED

JAN 1950

BUREAU V. S.



12896

## CERTIFICATE OF DEATH

Reg. Dist No. 28

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12,</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>511 Dunkirk Rd.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>			
				d. STREET ADDRESS <b>511 Dunkirk Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thekla Vollmer Way</b>				4. DATE OF DEATH Month Day Year <b>12-11 1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-1896</b>		9. AGE (In years last birthday) yrs <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>private schools</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Philip Vollmer</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Osann</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-30-0801</b>		17. INFORMANT Address <b>M.H. Way 511 Dunkirk Rd., Balto. 12, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARCINOMA OF UTERUS</b> <b>174x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>None</b>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Baltimore</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Sept 16</b> , 19 <b>57</b> , to <b>Dec 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec 9</b> , 19 <b>57</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>6210 YORK ROAD</b> DATE SIGNED <b>Dec 11 1957</b>							
ACTUAL SIGNATURE <b>A.S. Chalfant</b>				M.D. <b>BALTIMORE, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. A.S. CHALFANT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>12-13-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Scott Brooks</b>				ADDRESS <b>622 York Rd., Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 13 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mark L. Gray</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EC

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or to burial, cremation, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12897

# CERTIFICATE OF DEATH

12889

Items 8 & 9 Film G225 12/19/57

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo. Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>5yr5mths2dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale, Maryland 16</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS <b>4803 Riverdale Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Mae</b> Last <b>Weeks</b>				4. DATE OF DEATH Month <b>December</b> Day <b>1<sup>st</sup></b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1875</b> <b>Jan. 12, 1895</b>	
9. AGE (In years last birthday) <b>62 82yrs.</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b>15</b> Min.		IF UNDER 24 HRS Months <b>1</b> Days <b>15</b> Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>William R. Anderson</b>			
14. MOTHER'S MAIDEN NAME <b>Harriett Kohlenberg</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO <b>unknown</b>				17. Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of right lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 14</b> , 19 <b>57</b> , to <b>Dec. 1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 1<sup>st</sup></b> , 19 <b>57</b> , and that death occurred at <b>5:15 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL 12-2-57</b>							
ACTUAL SIGNATURE <b>Stella Wachslar</b> PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>12/4/57</b>		<b>Glenwood Cemetery Wash.</b>		<b>D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros. 1661 Socd pds</b>				24a. REC'D BY REGISTRAR <b>DEC 3 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

RECEIVED

REC 4 1957

BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12890

12898

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr4mths28dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>			
f. STREET ADDRESS <b>2430 Brambleton Rd.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Amelia Caroline Wegner</b>				4. DATE OF DEATH Month Day Year <b>December 6 1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1869</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>school</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles J. Wegner</b>				14. MOTHER'S MAIDEN NAME <b>Johanna Sleepack</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>1-5</b> DUE TO <b>With mitral insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malnutrition and dehydration</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 21</b> , 19 <b>57</b> , to <b>Dec. 6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 6</b> , 19 <b>57</b> , and that death occurred at <b>115 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 12-6-57</b>							
ACTUAL SIGNATURE <i>C. Eugene Watermann</i> PHYSICIAN'S NAME (Type) <b>C. Eugene Watermann, M. D.</b>				CATONSVILLE 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 9, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i> ADDRESS <b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 11 '57</b>		24b. REGISTRAR'S SIGNATURE <i>Rebecca</i>	

U. S.

1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>	
		f. STREET ADDRESS <u>Bacon Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH Elizabeth White</u>		4. DATE OF DEATH Month Day Year <u>Dec. 15 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 20 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min. <u>9 25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>White Hall</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Harris</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Amos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>220-301194</u>	
17. INFORMANT <u>Anita Tittle</u>		Address <u>White Hall MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Neck of right femur</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>OCT. 11, 1957</u> , to <u>DEC. 15, 1957</u> , that I last saw the deceased alive on <u>Dec. 14, 1957</u> , and that death occurred at <u>4:17 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. <u>PARKTON, MD</u> <u>12/15/57</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Dec 18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Margaret Spivey</u>		ADDRESS <u>Bacon Road</u>	24a. REC'D BY REGISTRAR <u>12-19-57</u>
		24b. REGISTRAR'S SIGNATURE <u>Buxilla Forward</u>	

RECEIVED

DEC 20 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

128938

12900

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklandville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklandville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		e. STREET ADDRESS <u>11111 Court Road</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Last <u>Whitridge</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John G. Whitridge</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Henderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized and coronary arteriosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 14</u> , 19 <u>57</u> to <u>Dec 15</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>57</u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter B. Buck</u> M.D. <u>185 Eager St Balto - 2</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>WALTER B. BUCK</u>		<u>185 EAGER ST BALTO-2</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Dec 17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Greenwood</u>		24a. REC'D BY REGISTRAR <u>DEC 17 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Walter B. Buck</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. 2

DEC 17 1907



CERTIFICATE OF DEATH

12893

Reg. Dist. No.

35~

1. PLACE OF DEATH o COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Middletown Rd.</u>		e. STREET ADDRESS <u>Middletown Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Eli</u> Middle <u>F</u> Last <u>Wilhelm</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26, 1875</u>
9. AGE (In years and birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Peter F. Wilhelm</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Morrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-2999A</u>	
17. INFORMANT Address <u>Mrs. Susan Wilhelm, Freeland Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
DUE TO (b) <u>Arteriosclerosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1940</u> to <u>Dec 7</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 6</u> 19 <u>57</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>Parkton, Md.</u>	
DATE SIGNED <u>12/9/57</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		<u>PARKTON Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Kortenstein</u>		24a. REC'D BY REGISTRAR <u>12/12/57</u>	
ADDRESS <u>New Freedom Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Freedom</u>	

DEPT. OF AGRICULTURE

1957

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**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The before copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12894

12902

# CERTIFICATE OF DEATH

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lodge Forest</u>		LENGTH OF STAY (in this place) <u>25 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lodge Forest</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2110 Oak Road</u>				STREET ADDRESS (If rural give location) <u>2110 Oak Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>FREDERICKA</u> <u>WILLS</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 6, 1957</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>August 5, 1874</u>		<b>9. AGE last birthday</b> <u>83</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Casper Gantz</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Stein</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No.</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Margaret Renner 2110 Oak Road.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Cerebrovascular Ht. Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from June 19 1955, to Dec. 19 1957, that I last saw the deceased alive on Dec. 19 1957, and that death occurred at 11:30 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>J. J. Mann</u>				<b>DATE SIGNED</b> <u>12-7-57</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Dec. 9, 1957</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Oak Lawn Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Colgate, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Lawrence L. Farley</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ullrich Funeral Home 2112 Dundalk Ave</u>			

U. S. A.

1957

W. A. R.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12903 CERTIFICATE OF DEATH

12895

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>20 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>255 Chatsworth Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
3. NAME OF DECEASED (Type or print) First <b>Viola</b> Middle <b>Wilson</b> Last <b>Wilson</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1897</b>
9. AGE (In years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Adam Keckner</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Martin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Melvin W. Wilson, Reisterstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sarcoidosis (Pulmonary)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 19, 1957</b> to <b>Dec. 24, 1957</b> , that I last saw the deceased alive on <b>December 24, 1957</b> , and that death occurred at <b>5: A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin E. Strobel</b>		ADDRESS (Street, city or town, state) <b>48 Main Street Reisterstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Martin E. Strobel M.D.</b>		DATE SIGNED <b>12/24/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 27/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>All Saints</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR <b>12-24-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary E. Eline</b>			

RECEIVED

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BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12896

Reg. Dist. No.

12904

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
 TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health,  
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WHITE HALL</u> LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE HALL</u> (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Graystone Rd.</u>		e. STREET ADDRESS <u>Graystone Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>William Leonard Wilson Jr</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1927</u>
9. AGE (In years last birthday) <u>30</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>crane operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>steel co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. L. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Delie Hoover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII, 43-46</u>		16. SOCIAL SECURITY NO. <u>219-22-3368</u>	
17. INFORMANT <u>Mrs. John Thomas</u>		Address <u>Graystone Rd., White Hall</u> Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> <u>77.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (e), stating the underlying cause lost. (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>G. H. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Methodist</u>
		22d. LOCATION (City, town, or county) <u>White Hall, Md.</u>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		ADDRESS <u>622 York Rd., Towson 4, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>DEC 13 57</u>
		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

RECEIVED

DEC

BUREAU A 3

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery Co</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>715-A GIST AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LYMAN HENRY WOLFF</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 19 1957</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 20, 1902</b>		9. AGE (In years last birthday) yrs <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EDITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOV. PRINTING</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANK A. WOLFF</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN M. JONES</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO <b>184-05-2372</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>1 YEAR</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>DEC 18, 1957</b> to <b>DEC 19, 1957</b> , that I last saw the deceased alive on <b>DEC 19, 1957</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED		ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town or county) <b>WASHINGTON, D.C.</b>		22e. (State) <b>D.C.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>		24. REC'D BY REGISTRAR DATE <b>1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Dorothy Howell</b>		24c. (City, town or county) <b>SILVER SPRING, MD.</b>		24d. (State) <b>MD.</b>		24e. (City, town or county) <b>SILVER SPRING, MD.</b>		24f. (State) <b>MD.</b>		24g. (City, town or county) <b>SILVER SPRING, MD.</b>		24h. (State) <b>MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

12906

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9 Film G-23 12/18/57 GTE

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2609 Gray Manor Terrace</b>				d. STREET ADDRESS <b>2609 Gray Manor Terrace</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MATILDA</b> Middle <b>WOODARD</b> Last <b>WOODARD</b>				4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>1877</b> <b>Feb. 16, 1874</b>		9. AGE (In years last birthday) <b>80 8/8 yrs.</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>V.G.F. Filer</b>				14. MOTHER'S MAIDEN NAME <b>Mary T. Hass</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Colie Bauer, 2609 Gray Manor Terrace</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-Sclerotic Cardio-Vas. Disease</b> DUE TO (c) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Time</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M. B. Davis</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M. B. Davis M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 410 Belair Road.</b>				24a. REC'D BY REGISTRAR <b>DATE 12/18/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Edith Hunsley</b>	

BUREAU OF

DEC 19

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12907

CERTIFICATE OF DEATH

Reg. Dist. No.

12899

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>24 Chatsworth Ave.</b>		d. STREET ADDRESS <b>24 Chatsworth Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hallie Elizabeth Woodward</b>		4. DATE OF DEATH Month Day Year <b>Dec. 14, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1891</b>
9. AGE (In years last birthday) yrs <b>66</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Barker</b>		14. MOTHER'S MAIDEN NAME <b>Frances Jane</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>213-34-0405</b>	
17. INFORMANT <b>John R. Gilbert, Reisterstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO-SCLEROTIC C.V. DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>48 HRS</b> <b>9 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>EMPHYSEMA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JULY 27, 1948</b> to <b>DEC. 14, 1957</b> , that I last saw the deceased alive on <b>DEC. 12, 1957</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Martin E. Strobel</b> M.D. <b>48 MAIN ST. REISTERSTOWN MD 12/15/57</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>MARTIN E. STROBEL</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 17, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Finksburg</b>		22d. LOCATION (City, town, or county) (State) <b>Finksburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>12-15-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>			

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12908

## CERTIFICATE OF DEATH

12904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write <b>Essex</b> and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write <b>Essex</b> and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John W. Wright</b> First Middle Last				4. DATE OF DEATH <b>Dec. 11 1957</b> Month Day Year			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-2-1900</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sea-Food</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-Employ</b>			
11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John W. Wright</b>				14. MOTHER'S MAIDEN NAME <b>Deahl</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-09-6809</b>			
17. INFORMANT <b>ANNIE WRIGHT</b> Address <b>(SAME)</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Chronic arteriosclerotic Cardio-vascular</b>							<b>10 yrs</b>
DUE TO <b>Heart; Coronary Artery Disease</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Heart; Coronary Artery Disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 1950</b> to <b>12/11/57</b> , 1957, that I last saw the deceased alive on <b>12/11/57</b> , 1957, and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James J. White</b>				ADDRESS (Street, city or town, state) <b>422 E. 2nd Ave, Baltimore 21, Md</b>			
PHYSICIAN'S NAME (Type) <b>James J. White</b>				DATE SIGNED <b>12/11/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-14-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CAK-LAWN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Connelly - Essex Md</b>				ADDRESS <b>Essex Md</b>		24a. REC'D BY REGISTRAR <b>16195</b>	
				24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12730

CERTIFICATE OF DEATH

12904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 N. Baltimore, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4610 Linden Ave</u>		d. STREET ADDRESS <u>1 4610 Linden Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>WRIGHT</u> Last <u>WRIGHT</u>		4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1868</u> AGE (In years last birthday) <u>89</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr Thompson</u> Address <u>4610 Linden - Balt, 27, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>None</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January, 1956</u> , to <u>Dec 24, 1957</u> , that I last saw the deceased alive on <u>20 Dec 1957</u> , and that death occurred at <u>8:47 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Goodman</u> M.D.		ADDRESS (Street, city or town, state) <u>1334 Sulphur Spring Rd. 2405, Balt, Md.</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, M.D.</u>		DATE SIGNED <u>Dec 27, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase Inc 1328 Sulphur Spring Rd</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. Edm. Theffery</u>	

BUREAU V. P.

1957

RECEIVED

## 12909 CERTIFICATE OF DEATH

12902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1400 Edmondson Ave.,</b>		e. STREET ADDRESS <b>1400 Edmondson Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>J.</b> Last <b>Wright</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>26,</b> Year <b>19 57.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1908</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beverage Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Churchill, Ltd.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter C. Wright</b>		14. MOTHER'S MAIDEN NAME <b>Maybelle Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Evelyn M. Wright</b>		Address <b>1400 Edmondson Ave.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Metastasis</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Larynx</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/30</b> , 19 <b>56</b> , to <b>12/26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/26</b> , 19 <b>57</b> , and that death occurred at <b>0300 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Victor F. King</b>		DATE SIGNED <b>12/27/57</b>	
PHYSICIAN'S NAME (Type) <b>VICTOR F. KING</b>		ADDRESS (Street, city or town, state) <b>Catonsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-30-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Strong</b>		24a. REC'D BY REGISTRAR <b>DEC 30 '57</b>	
ADDRESS <b>3207 W. 16th AVE</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 1 1957

BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12910 CERTIFICATE OF DEATH

12903  
Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>16 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>C</b> Last <b>WYN</b>				4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>19 57</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/9/94</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Henry Wynn</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Horton</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>			
16. SOCIAL SECURITY NO. <b>220-03-4820</b>				17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE RECTUM WITH GENERALIZED METASTASIS</b> <b>154X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>November 21, 19 57</b> , to <b>December 7, 19 57</b> , and that death occurred at <b>12:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b> DATE SIGNED <b>12/7/57</b> SIGNATURE <b>Chien Wei Lan</b> PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>				24a. REC'D BY REGISTRAR DATE <b>12/14/57</b>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <b>Rawson L. Farley</b>			

Charles R. Law Mortuary, 802-04 Madison Avenue, Balto., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12911 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

129048

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BALTIMORE</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE RURAL BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1733 FORREST AV</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>YAKEL</b>				<b>4. DATE OF DEATH</b> Month <b>Dec</b> Day <b>20</b> Year <b>19 57</b>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct 24, 1907</b>	
<b>9. AGE</b> (In years last birthday) <b>50</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Lumber</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Carroll Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Henry Yakel</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Johanna</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-07-7472</b>		<b>17. INFORMANT</b> Address <b>John Wm Byron 1733 Forrest Av (stepson)</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute occlusion of coronary artery</b> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>immed</b> <b>few hours</b>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <b>John C. Hyle</b>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <b>12-20-57</b>	
<b>EXAMINER'S NAME (Type)</b> <b>John C Hyle MD</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REINTERMENT (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12/24/57</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Moreland Mem Park</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Baltimore, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck</b>				<b>ADDRESS</b> <b>5305 Harford Road #14</b>		<b>24a. REG. BY REGISTRAR</b> <b>DEC 24 1957</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Dr. H. M. Brown</b>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THOMAS V. S.

1853

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12912 CERTIFICATE OF DEATH

12905

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b> c. LENGTH OF STAY IN 1b <b>41 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Baltimore (17)</b> d. STREET ADDRESS <b>2538 Sycamore Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>P</b> Last <b>YARBOROUGH</b>				4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1923</b>	
9. AGE (In years lost birthday) <b>34</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Yarbrough</b>				14. MOTHER'S MAIDEN NAME <b>Malinda Marrian</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>VW II</b>				16. SOCIAL SECURITY NO. <b>218-12-6857</b>		17. INFORMANT <b>Clin. Rec. Vet. Admin. Hosp., Ft. Howard, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRRHOSIS OF LIVER</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 11</b> , 19 <b>57</b> , to <b>Dec. 22</b> , 19 <b>57</b> . <del>XXXXXXXXXXXXXXXXXXXX</del> and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Ft. Howard, Md.</b> DATE SIGNED <b>12/22/57</b>							
ACTUAL SIGNATURE <b>Chien Wei Fan</b> M.D. <b>VAH, Ft. Howard, Md.</b>							
PHYSICIAN'S NAME (Type) <b>Chien Wei Lan, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b> ADDRESS _____				24a. REC'D BY REGISTRAR DATE <b>Dec. 31-57</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farber</b>	

Charles R. Law Mortuary, 802-04 Madison Ave., Balto., Md.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

JAN 2 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12913

## CERTIFICATE OF DEATH

12906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>29 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>W.</b> Last <b>YEAGER</b>		4. DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>2/2/1879</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineer WB &amp; A</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN T. YEAGER</b>		14. MOTHER'S MAIDEN NAME <b>ELLA CARROLL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obliterative pericarditis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Infarctive myocardial fibrosis</b> (c) <b>Arteriosclerotic cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Sept 121, 1928</b> to <b>Dec 17, 1957</b> that I last saw the deceased alive on <b>Dec 17, 1957</b> , and that death occurred at <b>5:15 A.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b> <b>12/17/57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonville 28, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/19/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Com.</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker + Son North + Penn. Ave. (7)</b>		24a. REC'D BY REGISTRAR <b>DEC 18 57</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Tucker</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



BUREAU V. 1

DEC 19 1957

RECEIVED